CLOZAPINE MONITORING REQUEST FORM

Test Required: Full Blood Count (ZFBC) ☐
Clozapine Level (CLOZ) ☐

Please send 2 EDTA tubes if both tests are requested

Last name:		
First name(s):		
ZTAS or DMS Monitoring Service number:		
SLAM Trust ID:		
Date of birth:	Sex:	Weight (kg):
Ward/Team	Consultant	
Date and time sample taken (24-hour clock) DD / MM / YY h : m		
Date and time of last clozapine dose (24-hour clock) DD / MM / YY h : m		
Clozapine dose (mg/d)	Tobacco smoker? ☐YES ☐NO	

Pathology Central Specimen Reception, Bessemer Wing, King's College Hospital
Customer Services: 0204 513 7300 Email: customerservices@synnovis.co.uk

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LF-CB-TOX-SLAMCLOZ v1.0
This form may be downloaded from: https://www.synnovis.co.uk/our-tests/clozapine-norclozapine