

# PLASMA CLOZAPINE ASSAY REQUEST FORM

\*\*\* Use separate form for other antipsychotic drug assay requests \*\*\*

Please send completed form with a blood sample (2 ml collected into EDTA tube or 1ml EDTA plasma) to:  
**TDM Section, Toxicology Unit, 3<sup>rd</sup> floor Bessemer Wing, King's College Hospital, Denmark Hill, London SE5 9RS**

Tel: 020 3299 5878, e-mail: [kch-tr.toxicology@nhs.net](mailto:kch-tr.toxicology@nhs.net)

*For result queries please contact customer services*

Tel: 020 4513 7300 e-mail: [customerservices@synnovis.co.uk](mailto:customerservices@synnovis.co.uk)

**\*\* Pack safely to Post Office regulations - Do not send with courier for FBC \*\***

- Samples should be taken 12 hours post-dose, collected prior to the morning sample in twice-daily dosing ("trough sample")
- **Addresses** to which the **report** is to be sent **must** be supplied; the **report** will be addressed to the **consultant**, unless otherwise specified.
- Assay results will be available within 2 working days of sample receipt
- **For information about electronic reporting please contact customer services**

## Patient

Last name:		
First name(s):		
Clozapine Monitoring Service number:		
NHS or Hospital number:		
Date of birth:	Sex: M / F	Weight (kg):
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)?	Smoker?	
	<input type="checkbox"/> YES <input type="checkbox"/> NO (includes eCig/NRT)	

Please affix CPMS, DMS, ZTAS or alternative label here if available

## Report and invoice

Assay requested by:
Phone number:
Email address:
Consultant:
Address for report:
Postcode
If this service has recently moved, please tick here <input type="checkbox"/>
Invoicing; is the organisation:
NHS / Private / Non-UK
Invoice address:
Purchase order number:

Reason for request:

<input type="checkbox"/> Baseline value?	<input type="checkbox"/> Poor / non-compliance?
<input type="checkbox"/> Dose correct?	<input type="checkbox"/> Drug interaction?
<input type="checkbox"/> Adverse reaction?	<input type="checkbox"/> Other (describe below)?

Other medication (please detail):