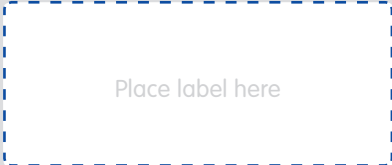
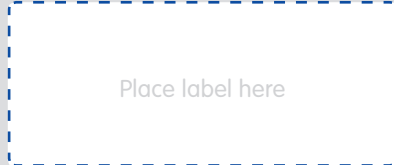
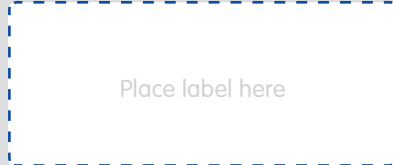
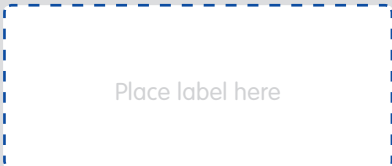
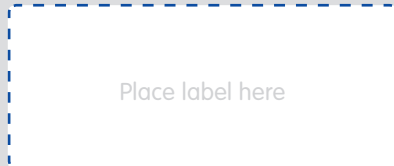
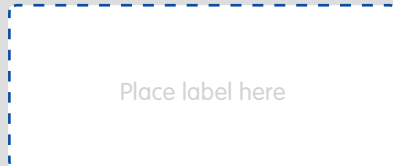


**REQUEST FOR CLOZAPINE LABELS**

Requested by:													
Facility Name:													
Address:													
Town/City:													
Postcode:						Signature / Date							
Telephone Number: <small>(It is essential to enter this number)</small>							d	d	m	m	y	y	y

**CLOZAPINE PATIENT LABELS REQUIRED:**

If you don't have labels, enter details below or add more labels if required;

Patient Name/Initials	Date of birth	ZTAS PIN

**PLEASE EMAIL / FAX THIS FORM TO MAGNA LABORATORIES ON 01989 763533**

Should you have any queries, please contact Magna Laboratories

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