



»» THERAPEUTIC DRUG MONITORING ASSAY REQUEST FORM

INSTRUCTIONS

- Blood sample to be collected in EDTA tubes, minimum of 2mL. Serum samples can be used.
- It is essential both sample and request are clearly identifiable with at least 3 forms of ID.
- Sample should be taken approximately 12 hours post-dose, except for aripiprazole and extended-release quetiapine which should be taken 24 hours post-dose.
- Contact information and addresses must be supplied for both reporting and invoicing. Failure to complete form will mean delayed reporting of results.
- Olanzapine samples must be in EDTA tubes and analysed within 72 hours or stored frozen (-20°C) as plasma.
- Kit items supplied by Magna Labs are for use in connection with Magna Labs pathology services only.
- Results are only sent to those named on form. Requesting reports to be sent to more than one email address indicates your acceptance of data sharing to the recipients.
- There will be a charge for this assay.

Please complete in block capitals, including email addresses

ASSAY REQUIRED

Aripiprazole

Haloperidol

Quetiapine

Clozapine

Olanzapine

Risperidone / Paliperidone

Assay requested by:

FIRSTNAME / SURNAME

Telephone number:

PATIENT

PLACE PATIENT ID STICKER HERE

At least 3 points of ID marked with * must be completed on SAMPLE and form

First name:*

Last name:*

Date of birth:*

DD-MM-YYYY

Sex:

Male

Female

NHS/H&C/CHI No.:*

Smoker:

YES

NO

Clozapine PIN:*

Zaponex (ZTAS)

Clozaril (CPMS)

Denzapine (DMS)

Total Daily dose (including units)

Dose Split:

YES

NO

or Depot/IM dose

When last dose taken:

DD-MM-YYYY

Time (24hrs):

HH : MM

When blood sample taken:

DD-MM-YYYY

Time (24hrs):

HH : MM

Name (Phlebotomist):

FIRSTNAME / SURNAME

Date:

DD-MM-YYYY

We handle confidential data in line with all relevant legislation. For details see the Privacy Notice on our website at www.magnalabs.co.uk

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REPORT

Consultant

Full name:

F I R S T N A M E / S U R N A M E

GMC number:

Facility:

Postcode:

Consultant report to be emailed to:

E-mail 1:

E-mail 2:

E-mail 3:

Pharmacy

Pharmacy name:

Pharmacist name:

F I R S T N A M E / S U R N A M E

Address:

Postcode:

Pharmacy report to be emailed to:

E-mail 1:

E-mail 2:

E-mail 3:

Invoice to:

Consultant

Pharmacy

Other - Please specify:

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