**Request for extension of clozapine blood test validity**

**Please complete as fully as possible**

Patient name:

Date of birth:

NHS number:

Ethnicity:

Diagnosis:

Current medication (please list all, with doses, frequencies and formulation):

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Formulation** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Current clozapine treatment**

Start date on clozapine:

Due date of next blood test:

Frequency of monitoring:

**Expected treatment gap**

Reason for expected treatment gap (i.e. explain why testing cannot be performed at the right time):

Anticipated duration of treatment gap (i.e. when can a blood test reasonably be expected to be collected):

Expected clinical consequence of a treatment gap:

**Prior clozapine treatment**

Please provide details of abnormal FBC results for this patient in any prior episodes of clozapine treatment

**Comorbidities**

Comorbid medical history:

Benign Ethnic Neutropenia Y/N