PLASMA ANTIPSYCHOTIC DRUG ASSAY REQUEST FORM

***** Use separate form for clozapine assay requests *****

Please send completed form with a blood sample (**4 ml** collected into **EDTA** tube or **2ml EDTA** plasma) to:

TDM Section, Toxicology Unit, 3rd floor Bessemer Wing, King's College Hospital, Denmark Hill, London SE5 9RS

Tel: 020 3299 5878, e-mail: *kch-tr.toxicology@nhs.net*

For result queries please contact customer services

Tel: 020 4513 7300 e-mail: customerservices@synnovis.co.uk

*** Pack safely to Post Office regulations ***

- 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 5 working days of sample receipt
- ***For information about electronic reporting please contact customer services***

Patient

Last name:

First name(s):

Drug assay required (please tick):

☐ Amisulpride ☐ Risperidone
☐ Aripiprazole ☐ Paliperidone
☐ Olanzapine ☐ Sulpiride
☐ Quetiapine

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 dose? *(24-hour clock)*

DD / MM / YY h : m

Drug dose (mg/d)?	*Smoker?* ☐YES ☐NO (includes eCig/NRT)

Reason for request:

☐ Baseline value? ☐ Poor / non-compliance?
☐ Dose correct? ☐ Drug interaction?
☐ Adverse reaction? ☐ Other (describe below)?

Other medication (please detail):

Report and invoice

Assay requested by:

Phone number:

E-mail address:

Consultant:

**Address for report:*

Postcode:

If this service has recently moved, please tick here ☐

**Invoicing; is the organisation:*

NHS / Private / Non-UK

Invoice address:

Purchase order number:

Please affix patient label here if available

This form may be downloaded from http://www.synnovis.co.uk/our-tests/amisulpride