**Proforma for Clozapine Injection Requests**

This form **must** be completed by a Consultant Psychiatrist and submitted to **both** the Chief Pharmacist and the Deputy Chief Medical Officer for approval via the generic inbox for medicines approvals medicine.approvals@lscft.nhs.uk

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| --- | --- |
| Patient Name: |  |
| NHS Number: |  |
| Date of Birth: |  |
| Inpatient ward: |  |
| Diagnosis/Indication for Clozapine: |  |
| Date MDT discussion including a  pharmacist was documented in  the clinical record |  |
| Date of peer review meeting |  |
| Date of SOAD approval |  |
| Name of Consultant |  |
| Signature of Consultant |  |

**1. Has the patient previously been prescribed Clozapine?**

# Yes No

**If yes, has the patient previously had a red result?**

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|  |

# Yes No

**If yes, has the patient previously had repeated amber results?**

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# Yes No

If yes, please provide information on response to treatment, any adverse effects, information on adherence, work undertaken to try and get the patient to accept oral clozapine and a rationale for why clozapine injection is being requested.

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# Medication History

Please provide details of the previous drug history, including responsivity, compliance, adverse drug reactions.

**Current Medication**

**Previous antipsychotic medication**

# Risk Factors

Please outline any significant physical health co-morbidities which may contra-indicate the use of Clozapine.

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# Outcome

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Request

Approved

Request Not Approved:

Reason

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| **Signed:**  **Chief**  **Pharmacist** |  | **Date** |  |
| **Signed:**  **Deputy Chief Medical Officer** |  | **Date** |  |