**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**  |   |