CLOZAPINE MONITORING FORM – PART A

(to be used after WA clozapine initiation and titration chart)

WARD_____

DOCTOR_____

Psychiatrist / Treating Doctor:

Monitoring clinic / GP:

Dispensing Pharmacy:

Please use I.D. label or block print

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

Patient Contact Number: | Height: _____m

Clozapine patient number (CPN): | Blood Group:

Date clozapine initiated: ____/____/____ **18 week clozapine completion date: ____/____/____**

CLINICAL REVIEW			Baseline prior to clozapine	Date	Date	Date	Date	Date	Date	Date	Date	Date
Baseline then weekly first 18 weeks, then every 28 days	**Dosage (mg): AM**											
	Dosage (mg): PM											
	Blood pressure – lying											
	Blood pressure – standing											
	Temperature (°C)											
	Heart rate (bpm)											
	Weight (kg)											
	Waist circumference (cm)											
	Cigarettes / day											
	WBC > 3.5 x 10^9/L AND NC > 2.0 x 10^9/L			Green	WBC > 3.0 – 3.5 x 10^9/L AND/OR NC 1.5 – 2.0 x 10^9/L				Amber	WBC < 3.0 x 10^9/L AND/OR NC < 1.5 x 10^9/L			Red
	FBC or WBC and differentials x10^9/L	**WBC**										
		NC										
Signs of infection (flu like symptoms, fever, malaise and myalgia)												
Signs of Cardiac illness (Tachycardia, chest pain, shortness of breath)												
GASS for Clozapine completed												
Constipation Assessment completed												
DETAILS OF PERSON COMPLETING THIS FORM			These are suggested guidelines only, refer to the treating psychiatrist for individual monitoring requirements									
Signature or initials												
Name (Please print)												

To be used in conjunction with Clozapine Monitoring form PART B

MR XXX **CLOZAPINE MONITORING FORM**

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