DO NOT WRITE IN MARGIN

Please use I.D. label or block print

CLOZAPINE MONITORING FORM

Hospital / Health Service

To be used after
WA Clozapine Initiation and Titration Chart

SURNAME	UMRN / MRN	
GIVEN NAMES	DOB	GENDER
ADDRESS	TELEPHONE	

Psychiatrist/Treating Doctor: **Monitoring clinic/GP:** **Dispensing Pharmacy:**

Patient Contact Number: **Height: _____ m** **Smoking status: Smoker ☐ Non smoker ☐**

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	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																			
	Temperature (ºC)																			
	Heart rate (bpm)																			
	Weight (kg)																			
	Waist circumference (cm)																			
	BMI																			
	Cigarettes/day																			
	FBC or WBC and differentials x10^9/L — WBC																			
	FBC or WBC and differentials x10^9/L — NC																			
	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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SIDE EFFECTS ENQUIRY (indicate Yes (Y) or NO (N) if side effects are present		This is not an exhaustive list. Please see product information																		
Neutropenia/Agranulocytosis																				
Myocarditis/Cardiomyopathy																				
Constipation																				
Seizures																				
Hypersalivation																				
Nocturnal Enuresis/incontinence																				
Sedation																				
Other side effects noted																				
DETAILS OF PERSON COMPLETING THIS FORM		These are suggested guidelines only, refer to the treating psychiatrist for individual monitoring requirements																		
Signature																				
Name (Please print)																				

CLOZAPINE MONITORING FORM

MRxxx

Please indicate N (Normal) or A/N (Abnormal) in relevant white box once test completed (grey boxes are not mandatory but repeat tests if clinically indicated)

CLINICAL REVIEW REMINDERS	Baseline	1 week	2 weeks	3 weeks	4 weeks	5 weeks	6 weeks	7 weeks	8 weeks	9 weeks	10 weeks	11 weeks	12 weeks	13 weeks	14 weeks	15 weeks	16 weeks	17 weeks	18 weeks	19 weeks to 6 mths
Date																				
Fasting plasma glucose &/or HbA1c																				
Fasting total cholesterol, LDL, HDL and triglycerides																				
Troponin																				
C-Reactive Protein																				
ECG	As clinically indicated					As indicated														
Urea and Electrolytes & Liver Function Test																				
Echocardiogram																				
Clozapine/Norclozapine levels (write value)																				
Beta HCG (female)																				
GP Letter (6 monthly)																				
Check current Care Plan (3- 6 monthly)																				

Ongoing monitoring	6 months	12 months	18 months	2 years	2.5 years	3 years	3.5 years	4 years	4.5 years	5 years	5.5 years	6 years	6.5 years	7 years	7.5 years	8 years	8.5 years	9 years	9.5 years	10 years
Date																				
Fasting plasma glucose &/ or HbA1c																				
Fasting total cholesterol LDL, HDL and triglycerides																				
Troponin																				
C-Reactive Protein																				
ECG																				
Urea and Electrolytes & Liver Function Test																				
Echocardiogram	**ClopineCentral™ recommends an Echo at Baseline, 3 mths, years 1, 2, 5 and 10. Repeat Echocardiogram as clinically indicated i.e. resting tachycardia, tachypnea, shortness of breath or hypotension**																			
Clozapine/Norclozapine levels (write value)																				
Beta HCG (female)																				
Full Physical Examination booked (annually)																				
GP Letter (6 monthly)																				
Check current Care Plan (3-6 monthly)																				

DETAILS OF PERSON COMPLETING THIS FORM	*These are suggested guidelines only, refer to the treating psychiatrist for individual monitoring requirements*
Signature	
Name (Please print)	

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