CLOZAPINE PRESCRIPTION

HOSPITAL NAME AND ADDRESS	*PATIENT IDENTIFIER*
	INITIALS NHS NUMBER

NAME		DOB	

Please dispense the following medication for the above individual who is an in-patient at this establishment according to the following dosage schedule (NB. STRIKE THROUGH UNUSED SECTIONS):

1. FOR INTIATION OF CLOZAPINE

DATE							
MORNING (mg)							
EVENING (mg)							
TOTAL DAILY DOSE (mg)							

2. FOR CONTINUATION OF CLOZAPINE DOSE

℞ Clozapine

Brand *(delete as appropriate)*	**Denzapine**	**Clozaril**	**Zaponex**
Formulation *(delete as appropriate)*	**Tablets**	**Orodispersible Tablets**	**Suspension**
Dose & frequency			
Period of treatment (please specify)	**____ days**		

If this dose or frequency is a change please tick (✓) this box: ❑

MEDICAL SIGNATURE		*QUALIFICATIONS*		*GMC NO*	
PRINT NAME		*DATE*			

1. **Email encrypted copy to dispensary@speedshealthcare.co.uk**
2. **Copy this form and retain as proof of ordering.**
   Post off original form immediately, using pre-paid envelopes to: *Speeds Healthcare, One Lakeside, Chester, CH4 9QT*

FAXED BY		*DATE & TIME SENT*	

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