



Health and Social Care
in Northern Ireland

Regional Clozapine Standard
Initiation Prescription,
Administration and Monitoring
Chart

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Clozapine Standard Initiation Prescription, Administration and Monitoring Chart

Use addressograph or write in CAPITAL LETTERS

Allergies and reaction _____ or NDKA

Name:	
Address:	
H&C number:	
DOB:	

The prescriber **MUST** sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.

ZTAS PIN		Consultant		Check Identity								
Ward/Location				Monitoring Requirements								
Week 1 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by		BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
	1	STAT @	12.5mg			Pre-dose						
						1hr post dose						
						2 hr post dose						
						3hr post dose						
						4hr post dose						
						5 hr post dose						
	2	am	12.5mg			Pre-dose						
			pm	12.5mg			6hrs post am dose					
	3	am	12.5mg			Pre-dose						
			pm	25mg			6hrs post am dose					
	4	am	25mg			Pre-dose						
			pm	25mg			6hrs post am dose					
	5	am	25mg			Pre-dose						
			pm	50mg			6hrs post am dose					
	6	am	25mg			Pre-dose						
			pm	75mg			6hrs post am dose					
	7	am	25mg			Pre-dose						
			pm	75mg			6hrs post am dose					
Print Name					Professional PIN	It is best practice that the first dose be given in the morning or early afternoon to allow for adequate monitoring however if the first dose is given at BEDTIME the monitoring AFTER the dose may not be required.						
Prescribers Signature		Sign here for standard titration	Sign here if standard titration changed	Date								
		ALTERED TITRATION CHART REQUIRED <input type="checkbox"/>		Prescribers Signature		Date						

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine				Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:				Ask DAILY about symptoms that warrant notifying medical staff immediately. (See Appendix 5 for further information)			
Taken	Reviewed	Comments	Signature	-BP – Systolic <100 or > 170, Diastolic <60 or > 100 -Or Postural drop of >30mmHg, -Or temp> 38.4° or <35.5° -Or pulse is in excess of 120bpm -Respiration rate <12 OR >20 breaths/min				Any signs of constipation Clear over-sedation Flu-like symptoms, malaise fatigue Chest pain, shortness of breath, dyspnoea, Tachypnoea Seizures/ myoclonic jerks Any other intolerable side effects			
<input type="checkbox"/>	FBC	<input type="checkbox"/>									
<input type="checkbox"/>	Troponin(*)	<input type="checkbox"/>									
<input type="checkbox"/>	CRP(*)	<input type="checkbox"/>									
	Medical review	<input type="checkbox"/>									
	GASS review	<input type="checkbox"/>									
	Weight	kg		CLOZAPINE STOPPED _(complete pathway) <input type="checkbox"/>		Prescribers Signature		Date			

Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

Name:		Age:		Sex: M / F	
Date					
Caffeine intake Cups of tea or coffee per day.....					
Has there been a recent change in your smoking habit No <input type="checkbox"/> Yes <input type="checkbox"/> Details below					
Increase/Decrease by Cigarettes per day					
<p>This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication. Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the end box if you found that the side effect distressed you.</p> <p style="text-align: right; font-size: small;">© 2007 Waddell & Taylor</p>					

Over the <u>past week</u>:	<i>Never</i>	<i>Once</i>	<i>A few times</i>	<i>Everyday</i>	<i>Tick this box if distressing</i>
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. I have experienced jerking limbs or muscles					
6. I have been drooling					
7. My vision has been blurry					
8. My mouth has been dry					
9. I have felt like I am going to be sick or have vomited					
10. I have felt gastric reflux or heartburn					
11 I have had problems opening my bowels (constipation/diarrhoea)					
12. I have wet the bed					
13. I have been passing urine more often					
14 I have been thirsty					
15 I have felt more hungry than usual or have gained weight					
16. I have been having sexual problems					

<p><i>I have also experienced</i> <i>(Please write down any other side effects of physical problems or complaints that you may have had over the last week)</i></p>
17
18
19
20

Staff Information

1. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week.

2. Scoring
 For questions 1-16 award
 0 points for an answer of “never”.
 1 point for the answer “once”,
 2 points for the answer “a few times”
 3 points for the answer “everyday”.

Total for all questions

3. For all patients a *total score* of:
 0-16 = absent/mild side effects
 17-32 = moderate side effects
 over 32 = severe side effects

4. Side effects covered by questions
- 1-2 Sedation and CNS side effects
 - 3 Postural hypotension
 - 4 Tachycardia
 - 5 Myoclonus
 - 6 Hypersalivation extra-pyramidal side effects
 - 7-8 Anticholinergic side effects
 - 9-10 Gastro-intestinal side effects
 - 11 Constipation/overflow
 - 12 Nocturnal enuresis
 - 13-14 Screening for diabetes mellitus
 - 15 weight gain
 - 16 Sexual dysfunction

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Question 17-20 invite the service user to report any other side effects or problems not already mentioned. These questions are not scored but may instigate a discussion with the service user if clinically appropriate.

Clozapine Standard Initiation Prescription, Administration and Monitoring Chart

Allergies and reaction	_____	or	NDKA <input type="checkbox"/>
The prescriber MUST sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.			

Use addressograph or write in CAPITAL LETTERS	
Name:	_____
Address:	_____
H&C number:	_____
DOB:	_____
Check Identity	

ZTAS PIN	_____	Consultant	_____
Ward/Location	_____		

						Monitoring Requirements						
Week 2 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by		BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
	8	am	50mg			Pre-dose						
		pm	75mg			6hrs post am dose						
	9	am	50mg			Pre-dose						
		pm	100mg			6hrs post am dose						
	10	am	50mg			Pre-dose						
		pm	100mg			6hrs post am dose						
	11	am	50mg			Pre-dose						
		pm	125mg			6hrs post am dose						
	12	am	75mg			Pre-dose						
		pm	125mg			6hrs post am dose						
	13	am	100mg			Pre-dose						
		pm	125mg			6hrs post am dose						
	14	am	100mg			Pre-dose						
		pm	150mg			6hrs post am dose						

Print Name	_____	Professional PIN	_____
Prescribers Signature	Sign here for standard titration	Sign here if standard titration changed	Date
ALTERED TITRATION CHART REQUIRED		<input type="checkbox"/>	Prescribers Signature
		Date	_____

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE (* for first FOUR weeks only) prescribing any further clozapine				Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:	Ask DAILY about symptoms that warrant notifying medical staff immediately. (See Appendix 5 for further information)
Taken	Reviewed	Comments	Signature		
<input type="checkbox"/>	FBC	<input type="checkbox"/>		-BP – Systolic <100 or > 170, Diastolic <60 or > 100 -Or Postural drop of >30mmHg, -Or temp> 38.4° or <35.5° -Or pulse is in excess of 120bpm -Respiration rate <12 OR >20 breaths/min	Any signs of constipation Clear over-sedation Flu-like symptoms, malaise fatigue Chest pain, shortness of breath, dyspnoea, Tachypnoea Seizures/ myoclonic jerks Any other intolerable side effects
<input type="checkbox"/>	Troponin(*)	<input type="checkbox"/>			
<input type="checkbox"/>	CRP(*)	<input type="checkbox"/>			
	Medical review	<input type="checkbox"/>			
	GASS review	<input type="checkbox"/>			
	Weight	kg		CLOZAPINE STOPPED ^(complete pathway) Ensure that clozapine chart is cancelled and kardex amended	<input type="checkbox"/> Prescribers Signature
		Date	_____		

Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

Name:		Age:		Sex: M / F
Date				
Caffeine intake Cups of tea or coffee per day.....				
Has there been a recent change in your smoking habit No <input type="checkbox"/> Yes <input type="checkbox"/> Details below				
Increase/Decrease by Cigarettes per day				
<p>This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication. Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the end box if you found that the side effect distressed you.</p> <p align="right"><small>© 2007 Waddell & Taylor</small></p>				

<i>Over the past week:</i>	<i>Never</i>	<i>Once</i>	<i>A few times</i>	<i>Everyday</i>	<i>Tick this box if distressing</i>
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. I have experienced jerking limbs or muscles					
6. I have been drooling					
7. My vision has been blurry					
8. My mouth has been dry					
9. I have felt like I am going to be sick or have vomited					
10. I have felt gastric reflux or heartburn					
11 I have had problems opening my bowels (constipation/diarrhoea)					
12. I have wet the bed					
13. I have been passing urine more often					
14 I have been thirsty					
15 I have felt more hungry than usual or have gained weight					
16. I have been having sexual problems					

<i>I have also experienced</i> <i>(Please write down any other side effects of physical problems or complaints that you may have had over the last week)</i>
17
18
19
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Staff Information

1. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week

2. Scoring

For questions 1-16 award
 0 points for an answer of "never".
 1 point for the answer "once",
 2 points for the answer "a few times"
 3 points for the answer "everyday".

Total for all questions

3. For all patients a *total score* of:

0-16 = absent/mild side effects
 17-32 = moderate side effects
 over 32 = severe side effects

4. Side effects covered by questions

- 1-2 Sedation and CNS side effects
- 3 Postural hypotension
- 4 Tachycardia
- 5 Myoclonus
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- 11 Constipation/overflow
- 12 Nocturnal enuresis
- 13-14 Screening for diabetes mellitus
- 15 weight gain
- 16 Sexual dysfunction

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Clozapine Standard Initiation Prescription, Administration and Monitoring Chart

Allergies and reaction _____ or NDKA

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Monitoring frequency of obs can be reduced as clinically indicated from this point onwards, indicate on chart as appropriate.

Use addressograph or write in CAPITAL LETTERS

Name: _____

Address: _____

H&C number: _____

DOB: _____

Check Identity

ZTAS PIN _____ Consultant _____

Ward/Location _____ **Monitoring Requirements** _____

Week 3 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by		BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
	15(*)	am	100mg			Pre-dose						
		pm	175mg			6hrs post am dose						
	16	am	100mg			Pre-dose						
		pm	200mg			6hrs post am dose						
	17	am	100mg			Pre-dose						
		pm	200mg			6hrs post am dose						
	18	am	100mg			Pre-dose						
		pm	200mg			6hrs post am dose						
	19	am	100mg			Pre-dose						
		pm	200mg			6hrs post am dose						
	20	am	100mg			Pre-dose						
		pm	200mg			6hrs post am dose						
	21	am	100mg			Pre-dose						
		pm	250mg			6hrs post am dose						

Print Name _____ Professional PIN _____

Prescribers Signature Sign here for standard titration _____ Sign here if standard titration changed _____ Date _____

ALTERED TITRATION CHART REQUIRED Prescribers Signature _____ Date _____

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Taken	Reviewed	Comments	Signature		
<input type="checkbox"/>	FBC	<input type="checkbox"/>		-BP – Systolic <100 or > 170, Diastolic <60 or > 100 -Or Postural drop of >30mmHg, -Or temp> 38.4° or <35.5° -Or pulse is in excess of 120bpm -Respiration rate <12 OR >20 breaths/min	Any signs of constipation Clear over-sedation Flu-like symptoms, malaise fatigue Chest pain, shortness of breath, dyspnoea, Tachypnoea Seizures/ myoclonic jerks Any other intolerable side effects
<input type="checkbox"/>	Troponin(*)	<input type="checkbox"/>			
<input type="checkbox"/>	CRP(*)	<input type="checkbox"/>			
	Medical review	<input type="checkbox"/>			
	GASS review	<input type="checkbox"/>			
	Weight	kg		CLOZAPINE STOPPED _(complete pathway) Ensure that clozapine chart is cancelled and kardex amended <input type="checkbox"/>	Prescribers Signature _____ Date _____

(*) Consider a clozapine assay on day 15

Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

Name:		Age:		Sex: M / F	
Date					
Caffeine intake Cups of tea or coffee per day.....					
Has there been a recent change in your smoking habit No <input type="checkbox"/> Yes <input type="checkbox"/> Details below					
Increase/Decrease by Cigarettes per day					
<p>This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.</p> <p>Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the end box if you found that the side effect distressed you.</p> <p style="text-align: right; font-size: small;">© 2007 Waddell & Taylor</p>					

Over the <u>past week</u>:	Never	Once	A few times	Everyday	Tick this box if distressing
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. I have experienced jerking limbs or muscles					
6. I have been drooling					
7. My vision has been blurry					
8. My mouth has been dry					
9. I have felt like I am going to be sick or have vomited					
10. I have felt gastric reflux or heartburn					
11 I have had problems opening my bowels (constipation/diarrhoea)					
12. I have wet the bed					
13. I have been passing urine more often					
14 I have been thirsty					
15 I have felt more hungry than usual or have gained weight					
16. I have been having sexual problems					

<p><i>I have also experienced</i> <i>(Please write down any other side effects of physical problems or complaints that you may have had over the last week)</i></p>
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19
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Staff Information

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2. Scoring

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 0 points for an answer of “never”.
 1 point for the answer “once”,
 2 points for the answer “a few times”
 3 points for the answer “everyday”.

Total for all questions

3. For all patients a *total score* of:

0-16 = absent/mild side effects
 17-32 = moderate side effects
 over 32 = severe side effects

4. Side effects covered by questions

- 1-2 Sedation and CNS side effects
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- 5 Myoclonus
- 6 Hypersalivation extra-pyramidal side effects
- 7-8 Anticholinergic side effects
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- 11 Constipation/overflow
- 12 Nocturnal enuresis
- 13-14 Screening for diabetes mellitus
- 15 weight gain
- 16 Sexual dysfunction

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Clozapine Standard Initiation Prescription, Administration and Monitoring Chart

Allergies and reaction

or NDKA

The prescriber MUST sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.

Monitoring frequency of obs can be reduced as clinically indicated, indicate on chart as appropriate.

Use addressograph or write in CAPITAL LETTERS

Name:	
Address:	
H&C number:	
DOB:	

ZTAS PIN

Consultant

Ward/Location

Monitoring Requirements

Check Identity

Week 4 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by		BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
	22	am	100mg			Pre-dose						
		pm	250mg			6hrs post am dose						
	23	am	100mg			Pre-dose						
		pm	250mg			6hrs post am dose						
	24	am	100mg			Pre-dose						
		pm	300mg			6hrs post am dose						
	25	am	100mg			Pre-dose						
		pm	300mg			6hrs post am dose						
	26	am	100mg			Pre-dose						
		pm	300mg			6hrs post am dose						
	27	am	100mg			Pre-dose						
		pm	300mg			6hrs post am dose						
	28	am	100mg			Pre-dose						
		pm	300mg			6hrs post am dose						

Print Name		Professional PIN	
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Prescribers Signature	Sign here for standard titration	Sign here if standard titration changed	Date	ALTERED TITRATION CHART REQUIRED <input type="checkbox"/>	Prescribers Signature	Date
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The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine

Taken	Reviewed	Comments	Signature
<input type="checkbox"/>	FBC	<input type="checkbox"/>	
<input type="checkbox"/>	Troponin(*)	<input type="checkbox"/>	
<input type="checkbox"/>	CRP(*)	<input type="checkbox"/>	
	Medical review	<input type="checkbox"/>	
	GASS review	<input type="checkbox"/>	
	Weight	kg	

Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:

- BP – Systolic <100 or > 170, Diastolic <60 or > 100
- Or Postural drop of >30mmHg,
- Or temp > 38.4° or <35.5°
- Or pulse is in excess of 120bpm
- Respiration rate <12 OR >20 breaths/min

Ask DAILY about symptoms that warrant notifying medical staff immediately. (See Appendix 5 for further information)

- Any signs of constipation
- Clear over-sedation
- Flu-like symptoms, malaise fatigue
- Chest pain, shortness of breath, dyspnoea,
- Tachypnoea
- Seizures/ myoclonic jerks
- Any other intolerable side effects

CLOZAPINE STOPPED (complete pathway)	Ensure that clozapine chart is cancelled and kardex amended	<input type="checkbox"/>	Prescribers Signature	Date
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Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

Name:		Age:		Sex: M / F
Date				
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<i>Over the past week:</i>	<i>Never</i>	<i>Once</i>	<i>A few times</i>	<i>Everyday</i>	<i>Tick this box if distressing</i>
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
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6. I have been drooling					
7. My vision has been blurry					
8. My mouth has been dry					
9. I have felt like I am going to be sick or have vomited					
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16. I have been having sexual problems					

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Total for all questions

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