Health and Social Care
in Northern Ireland

Regional Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

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Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

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

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.

ZTAS PIN		Consultant	
Ward/Location			

Week 1 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by
	1	STAT @	12.5mg		
	2	am	12.5mg		
		pm	12.5mg		
	3	am	12.5mg		
		pm	25mg		
	4	am	25mg		
		pm	25mg		
	5	am	25mg		
		pm	37.5mg		
	6	am	25mg		
		pm	37.5mg		
	7	am	25mg		
		pm	37.5mg		
Print Name					Professional PIN
Prescribers Signature		Sign here for standard titration		Sign here if standard titration changed	Date

Monitoring Requirements

	BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
Pre-dose						
1hr post dose						
2 hr post dose						
3hr post dose						
4hr post dose						
5 hr post dose						
6hr post dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						

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.

ALTERED TITRATION CHART REQUIRED	☐	Prescribers Signature		Date	

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine

Taken		Reviewed	Comments	Signature
☐	FBC	☐		
☐	Troponin(*)	☐		
☐	CRP(*)	☐		
	Medical review	☐		
	GASS review	☐		
	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	☐	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 ☐ Yes ☐ Details below

Increase/Decrease by ………. Cigarettes per day

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.

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Over the ***past week****:*	*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					

I have also experienced
(Please write down any other side effects of physical problems or complaints that you may have had over the last week)

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* *S*edation and CNS side effects
   - *3* *Postural hypotension*
   - *4* *Tachycardia*
   - *5* *Myoclonus*
   - *6* *Hypersalivation* extra-pyramidal side effects
   - *7-8* *A*nticholinergic side effects
   - *9-10* *G*astro-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 Slow Initiation Prescription, Administration and Monitoring Chart

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

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.

ZTAS PIN		Consultant	
Ward/Location			

Week 2 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by
	8	am	25mg		
		pm	50mg		
	9	am	25mg		
		pm	62.5mg		
	10	am	25mg		
		pm	75mg		
	11	am	25mg		
		pm	87.5mg		
	12	am	25mg		
		pm	100mg		
	13	am	25mg		
		pm	100mg		
	14	am	25mg		
		pm	100mg		
Print Name					Professional PIN
Prescribers Signature		Sign here for standard titration		Sign here if standard titration changed	Date

Monitoring Requirements

	BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						

ALTERED TITRATION CHART REQUIRED	☐	Prescribers Signature		Date	

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine

Taken		Reviewed	Comments	Signature
☐	FBC	☐		
☐	Troponin(*)	☐		
☐	CRP(*)	☐		
	Medical review	☐		
	GASS review	☐		
	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	☐	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 ☐ Yes ☐ Details below				
Increase/Decrease by ………. Cigarettes per day				

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.

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*Over the **past week**:*	*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					

I have also experienced *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)*
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 Slow 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 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			

Week 3 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by
	15(*)	am	37.5mg		
		pm	100mg		
	16	am	50mg		
		pm	100mg		
	17	am	50mg		
		pm	125mg		
	18	am	50mg		
		pm	150mg		
	19	am	50mg		
		pm	150mg		
	20	am	50mg		
		pm	150mg		
	21	am	50mg		
		pm	150mg		
Print Name					Professional PIN
Prescribers Signature		Sign here for standard titration		Sign here if standard titration changed	Date

Monitoring Requirements

	BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						

ALTERED TITRATION CHART REQUIRED	☐	Prescribers Signature		Date	

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine

Taken		Reviewed	Comments	Signature
☐	FBC	☐		
☐	Troponin(*)	☐		
☐	CRP(*)	☐		
	Medical review	☐		
	GASS review	☐		
	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	☐	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 ☐ Yes ☐ Details below				
Increase/Decrease by ………. Cigarettes per day				

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.

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*Over the **past week**:*	*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					

I have also experienced *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)*
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 *S*edation and CNS side effects
   3 *Postural hypotension*
   4 *Tachycardia*
   5 *Myoclonus*
   6 *Hypersalivation* extra-pyramidal side effects
   7-8 *A*nticholinergic side effects
   9-10 *G*astro-intestinal side effects
   11 *Constipation/overflow*
   12 *Nocturnal enuresis*
   13-14 Screening for diabetes mellitus
   15 weight gain
   16 *Sexual dysfunction*

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Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

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

Check Identity

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.

ZTAS PIN		Consultant	
Ward/Location			

Week 4 Date	Day	Time	Standard Dose	Alternate Dosing	Administered by
	22	am	50mg		
		pm	175mg		
	23	am	50mg		
		pm	200mg		
	24	am	50mg		
		pm	225mg		
	25	am	50mg		
		pm	250mg		
	26	am	50mg		
		pm	250mg		
	27	am	50mg		
		pm	250mg		
	28	am	50mg		
		pm	250mg		
Print Name					Professional PIN
Prescribers Signature		Sign here for standard titration		Sign here if standard titration changed	Date

Monitoring Requirements

	BP, Sitting	BP, Standing	Pulse	Temp (°C)	Respiration rate	Recorded by
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						
Pre-dose						
6hrs post am dose						

ALTERED TITRATION CHART REQUIRED	☐	Prescribers Signature		Date	

The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine				
Taken		Reviewed	Comments	Signature
☐	FBC	☐		
☐	Troponin(*)	☐		
☐	CRP(*)	☐		
	Medical review	☐		
	GASS review	☐		
	Weight	kg		

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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	☐	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 ☐ Yes ☐ Details below

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*Over the **past week**:*	*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					
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9. I have felt like I am going to be sick or have vomited					
10. I have felt gastric reflux or heartburn					
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16. I have been having sexual problems					

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

2. 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
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Total for all questions

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

4. Side effects covered by questions
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   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*
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   13-14 Screening for diabetes mellitus
   15 weight gain
   16 *Sexual dysfunction*

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