|  |
| --- |
| **Anti-seizure medication assay request form**  Please complete this form and send with a sample to:  **Therapeutic Drug Monitoring Unit, Chalfont Centre for Epilepsy, Chalfont St Peter, Gerrards Cross, SL9 0RJ**  **Tel:** **01494 601 423/4; email: TDM\_Unit@epilepsysociety.org.uk**  **\*\*\*** Pack sample safely according to UN3373 regulations – Send by Royal Mail or with courier **\*\*\***   1. Take the sample immediately **before** next oral dose (“trough sample”). 2. Both serum and plasma samples are suitable for analysis. 3. An **address** to which the **invoice** is to be sent **must** be supplied. 4. Information given here will be entered on a TDM Unit’s database and used to help interpret the result. 5. The **report** will be sent to the **requester**, unless other arrangements are specified or in place. |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient details** | | | | | | | | | |
| **Last name** | | ***First name(s)***  Enter FirstName | | | | **Date of birth** Enter Date | | ***Sex*** | |
| ***NHS No.***  Enter NHS No. | | ***Hospital No.***  Enter Hospital No.. | | | | ***Ethnicity***  Choose Ethnicity | | | ***Weight (KG)***  Enter Weight. |
|  | | | | | | | | | |
| **Sample Details** | | | | | | | | | |
| ***Sample type***  Sample Type | | ***Sample Date***  Enter Date | | ***Sample Time(HH:MM AM/PM)***  Choose Hours ***:*** Choose MinutesChoose AM/PM | | | | | |
|  | | | | | | | | | |
| **Dose Details** | | | | | | | | | |
| ***Anti-seizure medication(s) assay(s) requested***  ***1)*** Choose ASM  ***2)*** Choose ASM  ***3)*** Choose ASM  ***4)*** Choose ASM | | | | ***Dose of anti-seizure medication(s)***  ***1)*** Enter Dosage  ***2)*** Enter Dosage  ***3)*** Enter Dosage  ***4)*** Enter Dosage | | | | ***Dosage regimen of anti-seizure medication(s)***  ***1)*** Enter Regimen  ***2)*** Enter Regimen  ***3)*** Enter Regimen  ***4)*** Enter Regimen | |
| ***Date of last anti-seizure medication(s) dose*** Enter date | | | | | ***Time of last anti-seizure medication(s) dose(HH:MM AM/PM)***  Choose Hours ***:*** Choose MinutesChoose AM/PM | | | | |
| ***Other medication* *(drugs & doses)***  Enter Other Meds details | | | | | | | | | |
| ***Reason for assay and other information which may help interpret the result (duration of treatment, indication for which medication is being prescribed, response, etc.)***  Enter reason and other relevant information. | | | | | | | | | |
|  | | | | | | | | | |
| **Report Details** | | | | | | | **Invoice Details (if different from Report)** | | |
| ***Purchase Order*** | Enter Purchase Order | | | | | | ***Cost Center*** | Enter Cost Center | |
| ***House No / Name*** | Enter House No./Name | | | | | | ***House No / Name*** | Enter House No./Name | |
| ***Street*** | Enter Street | | | | | | ***Street*** | Enter Street | |
| ***Town/County*** | Enter Town | | | | | | ***Town/County*** | Enter Town | |
| ***Post Code*** | Enter Post Code | | | | | | ***Post Code*** | Enter Post Code | |
| ***Email Address*** | Enter Email | | | | | | ***Email Address*** | Enter Email | |
|  | | | | | | | | | |
| ***Requestor Details*** | | | | | | | | | |
| **Assay Requestor**Enter Requestor Name | | | ***Request Date***  Today’s Date | | | | | ***Reference Number***  Enter RefNO | |
| ***Consultant***  Enter Consultant Name | | | ***Mobile / Phone / bleep no***  Enter Phone No. | | | | | | |