

CLINICAL CENTRE INFORMATION

| | |
|--|--|
| Customer ID <input style="width: 90%;" type="text"/> | Requesting doctor <input style="width: 90%;" type="text"/> |
| | |
| Hospital/Clinic <input style="width: 90%;" type="text"/> | QUERIES: Name <input style="width: 90%;" type="text"/> |
| Address <input style="width: 90%;" type="text"/> | Telephone <input style="width: 90%;" type="text"/> |
| Postcode <input style="width: 90%;" type="text"/> | Fax <input style="width: 90%;" type="text"/> |
| | Email <input style="width: 90%;" type="text"/> |

PATIENT DETAILS

Complete ONLY if no label available

| | | | | | |
|--|---|--|--|--|--|
| Hospital/Clinic No. <input style="width: 90%;" type="text"/> | Sex | M <input type="checkbox"/> | F <input type="checkbox"/> | Other <input type="checkbox"/> | |
| Initials <input style="width: 90%;" type="text"/> | Weight | <input style="width: 90%;" type="text"/> | Height | <input style="width: 90%;" type="text"/> | |
| Date of birth | <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> | Viral load | <input style="width: 90%;" type="text"/> | CD4 | <input style="width: 90%;" type="text"/> |

ALWAYS complete

PRIORITY SAMPLES

Pregnancy (gestation ___ weeks) Paeds (<6yrs) Dialysis Liver failure Inpatient/ITU Other

DRUG(S) TO BE MEASURED

| Drug | Dose (mg) | Dosing frequency | Date started (if within last month) |
|------|-----------|---|-------------------------------------|
| | | OD <input type="checkbox"/> BD (equal) <input type="checkbox"/> Other, specify: _____ | |
| | | OD <input type="checkbox"/> BD (equal) <input type="checkbox"/> Other, specify: _____ | |
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| | | OD <input type="checkbox"/> BD (equal) <input type="checkbox"/> Other, specify: _____ | |
| | | OD <input type="checkbox"/> BD (equal) <input type="checkbox"/> Other, specify: _____ | |

HIV patients – Is this patient on ritonavir? Yes No If yes, state dose

REASON FOR TDM (tick more than one if applicable)

Pregnancy Paediatric Possible drug interaction Liver failure Suspected treatment failure Suspected toxicity (provide details below)
 Renal failure Other:

OTHER MEDICATIONS (include herbals, over-the-counter medicines, etc)

SAMPLE INFORMATION (example information in blue)

| Sample ID | Sample Type | Date sample taken | Time sample taken | Drug to be analysed | Time elapsed since last dose |
|-------------|---------------|-------------------|-------------------|---------------------|------------------------------|
| Eg: Q123456 | PLASMA | 28 Feb 2009 | 17:15 | Ribavirin | 10 H 15 MIN |
| | PLASMA | | | | H MIN |
| | PLASMA | | | | H MIN |
| | PLASMA | | | | H MIN |
| | PLASMA | | | | H MIN |

| | |
|------------------------------------|-----------------------------------|
| COMMENTS (priority samples) | COMMENTS (reasons for TDM) |
|------------------------------------|-----------------------------------|

FOR LAB21 USE ONLY Date of sample receipt _____ Lab21 ID _____

Please return the completed form, together with a minimum of 1ml plasma in 1.5 ml screw top plastic tubes to

Lab21 Ltd, 184 Cambridge Science Park, Cambridge, CB4 0GA

DX address: Lab21, DX 6055300, Cambridge 94 CB

T 01223 395 450 F 01223 395 451 E info@lab21.com