A PATIENT DATA FORM

Please complete this form using black ink.

Zaponex Treatment Access System

This form is used to register and de-register a patient with the Zaponex Treatment Access System (ZTAS®).

Patients who are treated with Zaponex® must be registered on the ZTAS database. Additionally, all patients prescribed Zaponex (or any other clozapine drug) experiencing a leukopenia and/or neutropenia, will be enrolled on a separate database, the Central Non Re-challenge Database (CNRD). The CNRD maintains a central record of such adverse reactions to prevent harmful re-exposure to clozapine. The CNRD is controlled by an independent company, CNRD 2002 Ltd.

☐ Registration ☐ De-registration

Patient details

NHS Number : _ _ _ - _ _ _ - _ _ _ _

Name : Surname Initials

First name

(Any known aliases for this patient should be completed in the Comments section for this patient)

Date of birth : d d m m y y y y Sex : ☐ Male ☐ Female

Race : ☐ Caucasian ☐ Afro-Caribbean ☐ Asian ☐ Mixed* ☐ Other*

* please specify :

Blood group : ☐ O- ☐ O+ ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ Not available

Patient is eligible for Zaponex : ☐ Yes ☐ No

Patient treatment status :

- Registration ☐ New ☐ On-Treatment ☐ Interrupted
- De-registration ☐ Transferred ☐ Discontinued ☐ Non Re-challengeable ☐ Deceased

On-treatment patients

Current monitoring frequency : ☐ Weekly ☐ Fortnightly ☐ 4-Weekly

Most recent start date clozapine therapy : d d m m y y y y

Shared care : ☐ Yes ☐ No

Most recent blood results	1	2	3 (most recent)
Date of analysis :	d d m m y y y y	d d m m y y y y	d d m m y y y y
White Blood Cell Count (x 10^9/L) :	.	.	.
Neutrophil Count (x 10^9/L) :	.	.	.
Platelet Count (x 10^9/L) :	.	.	.

New/interrupted patients (to be completed by ZTAS):

Patient in CNRD : ☐ Yes ☐ No Date : d d m m y y y y

Name : Signature : ZTAS Employee

Comments :

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Surname patient :

Consultant Psychiatrist:

Name : GMC :

Treatment location

Facility name : Ward :

Address :

Town/City : Postcode :

Telephone : Fax :

Contact number for patients :

Pharmacy

Pharmacy name :

Address :

Town/City :

Routine ZTAS blood samples will be tested using:

☐ ZTAS lab* ☐ Local lab ☐ POCT*

Local laboratory :

Address :

Town/City : Postcode :

Telephone : Fax :

* *Please provide details of the local laboratory used for urgent samples or as back-up to POCT.*

Blood sampling location *(address for sending the patient's blood sampling kits when ZTAS lab is used)*

Facility name :

Contact person :

Address :

Town/City : Postcode :

Telephone :

The information on your patient held on the ZTAS database will be processed in accordance with the Data Protection Act 1998 in order to monitor your patient's blood results and to assist you and/or other healthcare professionals to make medical decisions regarding such patient's health and to provide you and/or your patients with services connected with Zaponex. Your patient's personal data may be used, now or in the future, in connection with further research by Leyden Delta (or companies associated with Leyden Delta) in relation to Zaponex and services connected with Zaponex and may also be published (although your patient will not be identified in any publications resulting from such research). The information on your patient held on the CNRD will be held for the sole purpose of preventing re-exposure to clozapine and will only be made available to the suppliers of clozapine.

Under the Data Protection Act 1998, Leyden Delta is required to obtain and process personal data fairly and lawfully. Since it would not be appropriate for Leyden Delta to contact your patients to obtain their consent to such processing of personal data as outlined above, we request that you obtain your patient's consent regarding the processing of his/her personal data.

Completed by Consultant Psychiatrist or Pharmacist:

I certify that to the best of my knowledge the completed information is true and accurate and that I have explained to my patient the reason as described above for pocessing this information.

Name : GMC/GPC/PNI:*

* *Please circle appropiate.*

Date : d d m m y y y y Signature : *Signature*

Please fax this form to ZTAS on 0207 3655843

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