

A**>>> PATIENT DATA FORM**

Surname patient:

S U R N A M E

Responsible Consultant Psychiatrist*

Name

N A M E

G M C

* Or other relevant specialist in the context of Zaponex® (clozapine) treatment indications, as per SPC.

Treatment Location

Facility name

Postcode

Ward

Telephone

Fax

Primary (Hospital) Pharmacy

Pharmacy name

Postcode

Zaponex dispensed by another pharmacy in Dispensing or Homecare arrangement?

No

Yes*

* If yes, please complete Dispensing/ Homecare pharmacy

Dispensing/Homecare Pharmacy

Pharmacy name

Postcode

Blood Testing

Routine Blood Samples will be tested using:

ZTAS Lab

Local Lab

POCT

Local Lab used

e.g. urgent samples

Postcode

Local results must be analysed by a NEQAS (National External Quality Assurance Scheme) or equivalent certified laboratory, details of which must be registered with ZTAS.

Blood Sampling Location (address to send blood sampling kits when ZTAS Lab is used)

Facility name

Contact person

N A M E

Postcode

Telephone

Fax

DECLARATION

The information about 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 your patient's health and to provide you and/or your patients with services connected with ZTAS. Your patient's personal data and blood samples may be used now or in the future in connection with further research by Leyden Delta (or sponsors whether or not associated with Leyden Delta). Such purposes may or may not be related to Zaponex and/or services connected to it 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. Because it would not be appropriate for Leyden Delta to contact your patient to obtain their consent to such processing of personal data and blood samples as outlined above, we request that you obtain your patient's (or legal guardian's) consent regarding the processing of his/her personal data.

To be completed and signed by Supervising Consultant or ZTAS-registered pharmacist

I certify that, to the best of my knowledge, the information provided is true and accurate. I have explained to my patient/guardians that his/her information and blood samples relating to him/her will be processed as described above and I have obtained their informed or implied consent.

Name

N A M E

GMC / GPC / PNI*

* Please circle appropriate.

Date

D D - M M - Y Y Y Y

Signature

S I G N A T U R E

All Adverse Events reported to ZTAS will be escalated to the Leyden Delta Drug Safety Department and follow-up information may be requested of you.

Please fax this form to ZTAS on 0207 3655843