AA-Clozapine Patient Care Network

DISPOSITION

17-AA004_AAC0290E1

AA-CLOZAPINE PATIENT CARE NETWORK

Phone: **1-877-276-2569**

Website: www.aaspire.ca

Please complete and fax to:

1-866-836-6778

Patient Initials: _____ Patient PIN: _____

Date of Withdrawal: ___/___/___ (DD / MM / YYYY) Last Medication Date: ___/___/___ (DD / MM / YYYY)

REASON FOR WITHDRAWAL

☐ Patient Request (please describe):

☐ Physician Decision (please describe):

☐ Protocol Violation (please describe):

☐ Agranulocytosis/Neutropenia (please describe):

☐ Cadiovascular Toxicity (please describe):

☐ Seizure (please describe):

☐ Other Adverse Event (please describe):

☐ Other (please describe):

TERMINATION FORM COMPLETED BY:

☐ Physician

☐ AA Pharma Personal via Telephone Contact

Telephone Contact Date: ___/___/___ (DD / MM / YYYY)

_____ ___/___/___

Physician Signature (DD / MM / YYYY)

_____ ___/___/___

AA Pharma Employee (DD / MM / YYYY)