AASPIRE THE AA-Clozapine PATIENT CARE NETWORK

AA pharma

AA-CLOZAPINE PATIENT CARE NETWORK

17-AA004_AAC0140E1

HEMATOLOGY CONSULT INITIAL CHECKLIST

Date:	# of pages incl. cover:
To:	**AA-CLOZAPINE Patient Care Network** — **Tel: 1-877- 276-2569** **Fax: 1-866-836-6778**
Tel:	Email: aaspire@aapharma.ca
Fax:	Website: www.aaspire.ca

Patient PIN: _____

Date of Birth: _____

Healthcare Number: _____

Physician Name: _____

Telephone: _____ (Provide a direct Physician line/Cell number/Pager)

Email address: _____ (Required by hematologist for contact with physician)

Fax: _____

Please provide the following information for the initial assessment:

- ☐ All available CBC results (including Hob, platelets, and differential white cell counts)
- ☐ Ethnic background of the patient
- ☐ History of Clozapine therapy (dose, starting date, interruption)
- ☐ Concurrent medications, ETOH use
- ☐ Presence or absence of febrile symptom or other manifestations of infection
- ☐ Significant medical history

Comments:

Upon completion please have the information together with this cover faxed to **1-866-836-6778**.

Thank you for your assistance, should you have any questions or concerns or require any assistance please do not hesitate to contact us at **1-877-276-2569**. We would be more than happy to assist you.

AA-Clozapine Patient Care Network