CSAN
®CLOZARIL® (clozapine)
SUPPORT AND ASSISTANCE NETWORK

CSAN® FORM
(Check appropriate procedure below)

☐ Enrollment (please complete Sections 1-4)
☐ Modification (please complete and sign as applicable)
☐ Discontinuation (please complete Sections 1 & 5)

CSAN® FAX: 1-800-465-1312
CSAN® TEL.: 1-800-267-2726
BC ONLY, FAX TO:
1-604-689-1262

SECTION 1. Patient Information

New start ☐ Restart ☐ Indicate previous CSAN® number: | | | | | | | | | | | On clozapine since: _____

Frequency: 7 ☐ 14 ☐ 28 ☐

Patient's Initials: _____ (First name or initial) _____ (Last name or initial)

Sex: ☐ M ☐ F Status: ☐ Inpatient ☐ Outpatient

Date of Birth: _____ **YY** _____ **MM** _____ **DD** **Provincial HC# / File#** _____

Copay # _____

Race: ☐ Black ☐ Caucasian ☐ Asian ☐ Other (specify): _____

SECTION 2. Institution

Institution: _____ Affiliated: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Tel.: _____ Ext.: _____ Fax: _____

Laboratory: _____ Tel.: _____ Fax: _____

Local Case Coordinator

Name: _____ Tel.: _____ Ext.: _____ Fax: _____

Email: _____

SECTION 3. To be completed and signed by Chief Pharmacist or Delegate Pharmacist

Pharmacist: _____ Pharmacist License No.: _____

Pharmacy Name: _____ Address: _____

City: _____ Prov.: _____ Postal Code: _____

Tel.: _____ Ext.: _____ Fax: _____

Email: _____

I agree to dispense CLOZARIL® on a weekly, every-two-week or every-four-week basis upon confirmation of a blood test for the current period.

_____ Pharmacist Signature

Date: _____ **YY** _____ **MM** _____ **DD**

SECTION 4. To be completed and signed by Treating Physician or Authorized Nurse Practitioner†

I, the treating physician or authorized nurse practitioner, will ensure that blood testing (white blood cell count and differential) for this patient (identified above) as required by the CLOZARIL® Product Monograph is performed at the specified frequency. I understand that no pharmacy will dispense any other brand of clozapine to my patient without my prior knowledge and permission regarding which brand is being dispensed. In this way I will be able to inform the laboratory to send my patient's results to the appropriate manufacturer's clozapine database (CSAN®). I will not prescribe CLOZARIL® until the non-rechallengeable status of this patient has been verified.

I have informed the patient and he/she has not objected to the release of relevant safety information, to CSAN®, held within any other clozapine database of an approved manufacturer of clozapine in Canada, if needed for the safe utilization of this medication and/or for the continuous monitoring of the patient by CSAN®. The information which may be released includes, the non-rechallengeable/hematological status of the patient, white blood cell counts and absolute neutrophil counts, dates and other information as may be relevant to the safe treatment of the patient with CLOZARIL®. I confirm that I have appropriately informed the patient about the purpose and content of the CSAN® monitoring service.

Physician/Nurse Practitioner Name: _____ Prov. License No.: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Tel.: (office): _____ Ext.: _____ Fax: _____

Tel.: (other): _____ Ext.: _____ Email: _____

_____ Physician/Nurse Practitioner Signature

Date: _____ **YY** _____ **MM** _____ **DD**

SECTION 5. Treatment Discontinuation: CLOZARIL® treatment was discontinued mainly due to:

☐ Non compliance

☐ Hematological (specify) _____

☐ Other (specify) _____

☐ Side Effects ☐ Non-Serious ☐ Serious Specify _____

Completed by: _____ Tel.: _____

Date of discontinuation: _____ **YY** _____ **MM** _____ **DD**

Ext.: _____

For information on our Patient Privacy Policy please visit our Privacy Policy at www.hlstherapeutics.com

† In selected provinces. According to the College of Nurses guidelines/regulations for applicable province.

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Download an editable copy of this form at www.csan.ca
Thank You!