Month/Year: **Clozapine Medication Sheet**   Allergies:

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:	Generic:	*Clozapine*																															
	Brand:	*Clozaril*																															
	Strength:																																	
Stop:	Amount:	Dose:																															
	Frequency:	Special Instructions/Precautions: *Watch for signs of infection (e.g., elevated temperature, weakness, sore throat, etc.). Notify HCP when signs of infection are observed.*	Reason: *Helps to prevent hallucinations*
	Route:	*By Mouth*		

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:	*LABWORK*																																	
	NEXT ANC LABWORK	*Next lab date*																																
Stop:		Special Instructions/Precautions: *Ensure that the pharmacy has received copies of lab work results.*	Reason: *Prescribed Clozapine*

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:	Generic:																																	
	Brand:																																	
	Strength:																																	
Stop:	Amount:	Dose:																															
	Frequency:	Special Instructions/Precautions:	Reason:
	Route:		

Name:	CODES	Initials	Signature	Initials	Signature
	A-Absent				
	DP-Day Program				
	H-Hospital				
Site:	S-School				
	P-Packaged				
	W-Work				
	V-Vacation				
	LOA-Leave of Absence				
	OSA-Off Site Administration				

Accuracy check 1	Date/time	Accuracy check 2	Date/time