|  |  |  |  |
| --- | --- | --- | --- |
| Competency Evaluation Tool for ‘Individual-Specific’ Review of the  Clozapine (Clozaril) Therapy Protocol   |  | | --- | |  | | **Name of Individual:** | |  |   **Individual-Specific Clozapine (Clozaril) Protocol Review Guidelines**  *The ‘Individual-Specific’ Review must be completed by a Qualified Trainer* |

|  |  |  |
| --- | --- | --- |
|  | Review Components and Procedure | Comments |
| At the conclusion of this review, the Certified staff: | |  |
| 1. | Knows where to access and how to follow the individual’s Clozapine Protocol. |  |
| 2. | Has received a review of the individual’s Clozapine Protocol from the Trainer. |  |
| 3. | Knows how to contact the Authorized Prescriber (i.e., Health Care Provider [HCP]) who is ordering the individual’s Clozapine. |  |
| 4. | Knows how to contact the Pharmacy/Pharmacist, who is dispensing the individual’s Clozapine. |  |
| 5. | Knows the location of where the individual’s ANC lab work is obtained. |  |
| 6. | Knows the frequency and schedule of the ANC lab work ordered for the individual. |  |
| 7. | Knows how the ANC lab work results are received by the consulting pharmacy. |  |
| 8. | Knows the steps to follow when the ANC lab work is not completed as ordered. |  |
| 9. | Knows the steps to follow when medication is not received from the pharmacy. |  |
| 10. | Knows how changes are communicated to all staff (e.g., medication progress note, narrative note, flow sheet, etc.). |  |
| 11. | Knows when and how to contact the individual’s Health Care Provider and/or the MAP Consultant for any Clozapine related issues, questions, or concerns. |  |
| 12. | Knows the Service Provider Emergency procedure including how to contact 911. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **This form may be used for multiple Certified staff.** | | | | |
| **1.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **2.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **3**. Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
|  | | | | |
| **4.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **5.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **6.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **7.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **8.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **9.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
| **10.** Based on this guideline used for training, I, as Trainer, have determined that the Certified staff named below has attended the ‘Review of the Individual’s Clozapine Protocol’ for the **identified individual**. | | | | |
| Certified Staff’s Printed Name: | |  | Trainer’s Printed Name: |  |
| Certified Staff’s Signature: | |  | Trainer’s Signature: |  |
| Date: | |  | Trainer’s Contact Information: |  |
|  | | | | |