This form must be completed for all high dose therapy patients – preferably prior to commencing treatment. Name: DOB: CHI: Consultant: High dose therapy checklist - please circle as appropriate. PMH - contraindications/Cautions History of cardiac disorders? Ν Ν Hepatic impairment? Renal impairment Ν Obesity Ν Heavy smoker N Heavy alcohol intake Ν Old age Ν Details: If there are any relative contraindications highlighted please state reasons why high dose therapy is to continue: Rationale for High-Dose Antipsychotic Therapy During the switch of one antipsychotic to another Failure to respond to Clozapine Failure to tolerate Clozapine As a temporary measure during an exacerbation of illness Partial response to Clozapine: as augmentation Other: Consent obtained for high dose therapy Section 47 T2 🗌 T3 🗌 Patient Consent Record of clinical monitoring (tick box when occurs) on 3 month basis and then annually. If results are abnormal, record in nursing / medical notes & inform the patients consultant. It is not anticipated that every patient will have CGI, HoNoS, GASS & LUNSERS performed but formal assessment of progress & side-effects is good practice, HDAT Pre-HDAT On going monitoring Date Patient consented or declined monitoring Drug(s) and doses % BNF max Possible drug interactions ECG (tick if ok) U&Es (tick if ok) LFTs (tick if FBC (tick if ok)

BP (mmHg) Pulse Temp (°C)					
Pulse					
Temp (°C)					
CGI					
HoNos					
CGI HoNos GASS LUNSERs					
LUNSERs					