
# Regional Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

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# BHSCT Clozapine Community Initiation Administration & Monitoring Chart

| Use addressograph or write in CAPITAL LETTERS | |
|---|---|
| **Name:** | |
| **Address:** | |
| **H&C number:** | |
| **DOB:** | |

Check Identitv

| Allergies and reaction | | or | NDKA ☐ |
|---|---|---|---|

The prescriber MUST sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.

| ZTAS PIN | | Consultant | |
|---|---|---|---|
| Ward/Location | | **Monitoring Requirements** | |

| Week 1 Date | Day | Time | Standard Dose | Alternate Dosing | Administered by |
|---|---|---|---|---|---|
| | 1 | STAT @ | 12.5mg | | |
| | 2 | am | 12.5mg | | |
| | | pm | 12.5mg | | |
| | 3 | am | 12.5mg | | |
| | | pm | 25mg | | |
| | 4 | am | 12.5mg | | |
| | | pm | 25mg | | |
| | 5 | am | 12.5mg | | |
| | | pm | 25mg | | |
| | 6 | am | 25mg | | |
| | | pm | 25mg | | |
| | 7 | am | 25mg | | |
| | | pm | 37.5mg | | |
| **Print Name** | | | | | Professional PIN |
| **Prescribers Signature** | | Sign here for standard titration | | Sign here if standard titration changed | Date |

| | BP, Sitting | BP, Standing | Pulse | Temp (°C) | Respiration rate | Recorded by |
|---|---|---|---|---|---|---|
| Pre-dose | | | | | | |
| 1hr post dose | | | | | | |
| 2 hr post dose | | | | | | |
| 3hr post dose | | | | | | |
| 4hr post dose | | | | | | |
| 5 hr post dose | | | | | | |
| 6hr post dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |

**It is best practice that the first dose be given in the morning or early afternoon to allow for adequate monitoring however if the first dose is given at BEDTIME the monitoring AFTER the dose may not be required.**

| ALTERED TITRATION CHART REQUIRED | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

**The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine**

| Taken | | Reviewed | Comments | Signature |
|---|---|---|---|---|
| ☐ | FBC | ☐ | | |
| ☐ | Troponin(*) | ☐ | | |
| ☐ | CRP(*) | ☐ | | |
| | Medical review | ☐ | | |
| | GASS review | ☐ | | |
| | Weight | kg | | |

**Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:**

-BP – Systolic <100 or > 170, Diastolic <60 or > 100
-Or Postural drop of >30mmHg,
-Or temp> 38.4° or <35.5°
-Or pulse is in excess of 120bpm
-Respiration rate <12 OR >20 breaths/min

**Symptoms that warrant notifying medical staff immediately (See Appendix 5 for further information)**

Any signs of constipation
Clear over-sedation
Flu-like symptoms, malaise fatigue
Chest pain, shortness of breath, dyspnoea, Tachypnoea
Seizures/ myoclonic jerks
Any other intolerable side effects

| CLOZAPINE STOPPED(complete pathway) Ensure that clozapine chart is cancelled and kardex amended | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

# Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

| | | | | |
|---|---|---|---|---|
| **Name:** | | **Age:** | | **Sex: M / F** |
| **Date** | | | | |

**Caffeine intake Cups of tea or coffee per day……**

**Has there been a recent change in your smoking habit No ☐ Yes ☐ Details below**

**Increase/Decrease by ……. Cigarettes per day**

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the **end** box if you found that the side effect distressed you.



| *Over the **past week**:* | *Never* | *Once* | *A few times* | *Everyday* | *Tick this box if distressing* |
|---|---|---|---|---|---|
| 1. I felt sleepy during the day | | | | | |
| 2. I felt drugged or like a zombie | | | | | |
| 3. I felt dizzy when I stood up and/or have fainted | | | | | |
| 4. I have felt my heart beating irregularly or unusually fast | | | | | |
| 5. I have experienced jerking limbs or muscles | | | | | |
| 6. I have been drooling | | | | | |
| 7. My vision has been blurry | | | | | |
| 8. My mouth has been dry | | | | | |
| 9. I have felt like I am going to be sick or have vomited | | | | | |
| 10. I have felt gastric reflux or heartburn | | | | | |
| 11 I have had problems opening my bowels (constipation/diarrhoea) | | | | | |
| 12. I have wet the bed | | | | | |
| 13. I have been passing urine more often | | | | | |
| 14 I have been thirsty | | | | | |
| 15 I have felt more hungry than usual or have gained weight | | | | | |
| 16. I have been having sexual problems | | | | | |

| ***I have also experienced*** *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)* |
|---|
| 17 |
| *18* |
| *19* |
| *20* |

## Staff Information

1. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week.

2. Scoring

   For questions 1-16 award

   0 points for an answer of "never".
   1 point for the answer "once",
   2 points for the answer "a few times"
   3 points for the answer "everyday".

Total for all questions

3. For all patients a *total score* of:

   *0-16* = absent/mild side effects
   *17-32* = moderate side effects
   *over 32* = severe side effects

4. Side effects covered by questions

   *1-2* *S*edation and CNS side effects
   *3* *Postural hypotension*
   *4* *Tachycardia*
   *5* *Myoclonus*
   *6* *Hypersalivation* extra-pyramidal side effects
   *7-8* *A*nticholinergic side effects
   *9-10* *G*astro-intestinal side effects
   *11* *Constipation/overflow*
   *12* *Nocturnal enuresis*
   *13-14 Screening for diabetes mellitus*
   *15* weight gain
   *16* *Sexual dysfunction*

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Question 17-20 invite the service user to report any other side effects or problems not already mentioned. These questions are not scored but may instigate a discussion with the service user if clinically appropriate.

# Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

| Use addressograph or write in CAPITAL LETTERS | |
|---|---|
| **Name:** | |
| **Address:** | |
| **H&C number:** | |
| **DOB:** | |

Check Identity

| Allergies and reaction | | or | NDKA ☐ |
|---|---|---|---|

The prescriber MUST sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.

| ZTAS PIN | | Consultant | |
|---|---|---|---|
| Ward/Location | | **Monitoring Requirements** | |

| Week 2 Date | Day | Time | Standard Dose | Alternate Dosing | Administered by |
|---|---|---|---|---|---|
| | 8 | am | 25mg | | |
| | | pm | 50mg | | |
| | 9 | am | 25mg | | |
| | | pm | 62.5mg | | |
| | 10 | am | 50mg | | |
| | | pm | 50mg | | |
| | 11 | am | 50mg | | |
| | | pm | 50mg | | |
| | 12 | am | 50mg | | |
| | | pm | 50mg | | |
| | 13 | am | 50mg | | |
| | | pm | 75mg | | |
| | 14 | am | 62.5mg | | |
| | | pm | 75mg | | |
| **Print Name** | | | | | Professional PIN |
| **Prescribers Signature** | | Sign here for standard titration | | Sign here if standard titration changed | Date |

| | BP, Sitting | BP, Standing | Pulse | Temp (°C) | Respiration rate | Recorded by |
|---|---|---|---|---|---|---|
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |

| ALTERED TITRATION CHART REQUIRED | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

**The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine**

| Taken | | Reviewed | Comments | Signature |
|---|---|---|---|---|
| ☐ | FBC | ☐ | | |
| ☐ | Troponin(*) | ☐ | | |
| ☐ | CRP(*) | ☐ | | |
| | Medical review | ☐ | | |
| | GASS review | ☐ | | |
| | Weight | kg | | |

**Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:**

-BP – Systolic <100 or > 170, Diastolic <60 or > 100
-Or Postural drop of >30mmHg,
-Or temp> 38.4° or <35.5°
-Or pulse is in excess of 120bpm
-Respiration rate <12 OR >20 breaths/min

**Symptoms that warrant notifying medical staff immediately (See Appendix 5 for further information)**

Any signs of constipation
Clear over-sedation
Flu-like symptoms, malaise fatigue
Chest pain, shortness of breath, dyspnoea, Tachypnoea
Seizures/ myoclonic jerks
Any other intolerable side effects

| CLOZAPINE STOPPED(complete pathway) Ensure that clozapine chart is cancelled and kardex amended | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

# Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

| | | | | |
|---|---|---|---|---|
| **Name:** | | **Age:** | | **Sex: M / F** |
| **Date** | | | | |

**Caffeine intake Cups of tea or coffee per day……**

**Has there been a recent change in your smoking habit No ☐ Yes ☐ Details below**

**Increase/Decrease by ……. Cigarettes per day**

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the **end** box if you found that the side effect distressed you.



| *Over the **past week**:* | *Never* | *Once* | *A few times* | *Everyday* | *Tick this box if distressing* |
|---|---|---|---|---|---|
| 1. I felt sleepy during the day | | | | | |
| 2. I felt drugged or like a zombie | | | | | |
| 3. I felt dizzy when I stood up and/or have fainted | | | | | |
| 4. I have felt my heart beating irregularly or unusually fast | | | | | |
| 5. I have experienced jerking limbs or muscles | | | | | |
| 6. I have been drooling | | | | | |
| 7. My vision has been blurry | | | | | |
| 8. My mouth has been dry | | | | | |
| 9. I have felt like I am going to be sick or have vomited | | | | | |
| 10. I have felt gastric reflux or heartburn | | | | | |
| 11 I have had problems opening my bowels (constipation/diarrhoea) | | | | | |
| 12. I have wet the bed | | | | | |
| 13. I have been passing urine more often | | | | | |
| 14 I have been thirsty | | | | | |
| 15 I have felt more hungry than usual or have gained weight | | | | | |
| 16. I have been having sexual problems | | | | | |

| ***I have also experienced*** *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)* |
|---|
| 17 |
| *18* |
| *19* |
| *20* |

## Staff Information

1. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week.

2. Scoring

For questions 1-16 award

0 points for an answer of "never".
1 point for the answer "once",
2 points for the answer "a few times"
3 points for the answer "everyday".

Total for all questions

3. For all patients a *total score* of:

*0-16* = absent/mild side effects
*17-32* = moderate side effects
*over 32* = severe side effects

4. Side effects covered by questions

*1-2* Sedation and CNS side effects
*3* *Postural hypotension*
*4* *Tachycardia*
*5* *Myoclonus*
*6* *Hypersalivation* extra-pyramidal side effects
*7-8* Anticholinergic side effects
*9-10* Gastro-intestinal side effects
*11* *Constipation/overflow*
*12* *Nocturnal enuresis*
*13-14 Screening for diabetes mellitus*
*15* weight gain
*16* *Sexual dysfunction*

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Question 17-20 invite the service user to report any other side effects or problems not already mentioned. These questions are not scored but may instigate a discussion with the service user if clinically appropriate.

# Clozapine Slow Initiation Prescription, Administration and Monitoring Chart

| Use addressograph or write in CAPITAL LETTERS | |
|---|---|
| **Name:** | |
| **Address:** | |
| **H&C number:** | |
| **DOB:** | |

Check Identity

| Allergies and reaction | | or | NDKA ☐ |
|---|---|---|---|

The prescriber MUST sign the chart at the start of each week and insert the appropriate date in each of the boxes provided for the applicable week. Please refer to the main prescription kardex for any other medication. If using an alternative dosing regime, cancel out the suggested (morning/evening) dose by drawing a diagonal line through it and ensure the prescriber signature box for that column is signed and dated. The staff supervising the administration of clozapine should sign in the "Administered by" column beside the relevant dose. Please specify reason for any omitted doses. The monitoring record should be completed and signed in the available box. Ensure that when necessary NEWS is recorded and scored.
Monitoring frequency of obs can be reduced as clinically indicated from this point onwards, indicate on chart as appropriate.

| ZTAS PIN | | Consultant | |
|---|---|---|---|
| Ward/Location | | **Monitoring Requirements** | |

| Week 3 Date | Day | Time | Standard Dose | Alternate Dosing | Administered by |
|---|---|---|---|---|---|
| | 15(*) | am | 75mg | | |
| | | pm | 75mg | | |
| | 16 | am | 75mg | | |
| | | pm | 100mg | | |
| | 17 | am | 100mg | | |
| | | pm | 100mg | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Professional PIN |
| **Prescribers Signature** | | Sign here for standard titration | | Sign here if standard titration changed | Date |

| | BP, Sitting | BP, Standing | Pulse | Temp (°C) | Respiration rate | Recorded by |
|---|---|---|---|---|---|---|
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |

| ALTERED TITRATION CHART REQUIRED | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

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| Taken | | Reviewed | Comments | Signature |
|---|---|---|---|---|
| ☐ | FBC | ☐ | | |
| ☐ | Troponin(*) | ☐ | | |
| ☐ | CRP(*) | ☐ | | |
| | Medical review | ☐ | | |
| | GASS review | ☐ | | |
| | Weight | kg | | |

**Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:**

-BP – Systolic <100 or > 170, Diastolic <60 or > 100
-Or Postural drop of >30mmHg,
-Or temp> 38.4° or <35.5°
-Or pulse is in excess of 120bpm
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**Symptoms that warrant notifying medical staff immediately (See Appendix 5 for further information)**

Any signs of constipation
Clear over-sedation
Flu-like symptoms, malaise fatigue
Chest pain, shortness of breath, dyspnoea, Tachypnoea
Seizures/ myoclonic jerks
Any other intolerable side effects

| CLOZAPINE STOPPED(complete pathway) Ensure that clozapine chart is cancelled and kardex amended | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

***(*) Consider a clozapine assay on day 15***

# Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

| | | | | |
|---|---|---|---|---|
| **Name:** | | **Age:** | | **Sex: M / F** |
| **Date** | | | | |

**Caffeine intake Cups of tea or coffee per day……**

**Has there been a recent change in your smoking habit No ☐ Yes ☐ Details below**

**Increase/Decrease by ……. Cigarettes per day**

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| *Over the **past week**:* | *Never* | *Once* | *A few times* | *Everyday* | *Tick this box if distressing* |
|---|---|---|---|---|---|
| 1. I felt sleepy during the day | | | | | |
| 2. I felt drugged or like a zombie | | | | | |
| 3. I felt dizzy when I stood up and/or have fainted | | | | | |
| 4. I have felt my heart beating irregularly or unusually fast | | | | | |
| 5. I have experienced jerking limbs or muscles | | | | | |
| 6. I have been drooling | | | | | |
| 7. My vision has been blurry | | | | | |
| 8. My mouth has been dry | | | | | |
| 9. I have felt like I am going to be sick or have vomited | | | | | |
| 10. I have felt gastric reflux or heartburn | | | | | |
| 11 I have had problems opening my bowels (constipation/diarrhoea) | | | | | |
| 12. I have wet the bed | | | | | |
| 13. I have been passing urine more often | | | | | |
| 14 I have been thirsty | | | | | |
| 15 I have felt more hungry than usual or have gained weight | | | | | |
| 16. I have been having sexual problems | | | | | |

| ***I have also experienced*** *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)* |
|---|
| 17 |
| *18* |
| *19* |
| *20* |

## Staff Information

1. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week.

2. Scoring

   For questions 1-16 award

   0 points for an answer of "never".
   1 point for the answer "once",
   2 points for the answer "a few times"
   3 points for the answer "everyday".

Total for all questions

3. For all patients a *total score* of:

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   *17-32* = moderate side effects
   *over 32* = severe side effects

4. Side effects covered by questions

   *1-2* Sedation and CNS side effects
   *3* *Postural hypotension*
   *4* *Tachycardia*
   *5* *Myoclonus*
   *6* *Hypersalivation* extra-pyramidal side effects
   *7-8* Anticholinergic side effects
   *9-10* Gastro-intestinal side effects
   *11* *Constipation/overflow*
   *12* *Nocturnal enuresis*
   *13-14 Screening for diabetes mellitus*
   *15* weight gain
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The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

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|---|---|
| **Name:** | |
| **Address:** | |
| **H&C number:** | |
| **DOB:** | |

Check Identity

| Allergies and reaction | | or | NDKA ☐ |
|---|---|---|---|

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Monitoring frequency of obs can be reduced as clinically indicated from this point onwards, indicate on chart as appropriate.

| ZTAS PIN | | Consultant | |
|---|---|---|---|
| Ward/Location | | **Monitoring Requirements** | |

| Week 4 Date | Day | Time | Standard Dose | Alternate Dosing | Administered by |
|---|---|---|---|---|---|
| | 22 | am | 50mg | | |
| | | pm | 175mg | | |
| | 23 | am | 50mg | | |
| | | pm | 200mg | | |
| | 24 | am | 50mg | | |
| | | pm | 225mg | | |
| | 25 | am | 50mg | | |
| | | pm | 250mg | | |
| | 26 | am | 50mg | | |
| | | pm | 250mg | | |
| | 27 | am | 50mg | | |
| | | pm | 250mg | | |
| | 28 | am | 50mg | | |
| | | pm | 250mg | | |
| **Print Name** | | | | | Professional PIN |
| **Prescribers Signature** | | Sign here for standard titration | | Sign here if standard titration changed | Date |

| | BP, Sitting | BP, Standing | Pulse | Temp (°C) | Respiration rate | Recorded by |
|---|---|---|---|---|---|---|
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |
| Pre-dose | | | | | | |
| 6hrs post am dose | | | | | | |

| ALTERED TITRATION CHART REQUIRED | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

**The following MUST be ordered, reviewed and actioned ONCE WEEKLY BEFORE(* for first FOUR weeks only) prescribing any further clozapine**

| Taken | | Reviewed | Comments | Signature |
|---|---|---|---|---|
| ☐ | FBC | ☐ | | |
| ☐ | Troponin(*) | ☐ | | |
| ☐ | CRP(*) | ☐ | | |
| | Medical review | ☐ | | |
| | GASS review | ☐ | | |
| | Weight | kg | | |

**Withhold the dose, seek medical advice and initiate additional monitoring in NEWS observations chart as instructed if:**

-BP – Systolic <100 or > 170, Diastolic <60 or > 100
-Or Postural drop of >30mmHg,
-Or temp> 38.4° or <35.5°
-Or pulse is in excess of 120bpm
-Respiration rate <12 OR >20 breaths/min

**Symptoms that warrant notifying medical staff immediately (See Appendix 5 for further information)**

Any signs of constipation
Clear over-sedation
Flu-like symptoms, malaise fatigue
Chest pain, shortness of breath, dyspnoea, Tachypnoea
Seizures/ myoclonic jerks
Any other intolerable side effects

| CLOZAPINE STOPPED(complete pathway) Ensure that clozapine chart is cancelled and kardex amended | ☐ | Prescribers Signature | | Date | |
|---|---|---|---|---|---|

## Glasgow Antipsychotic Side-effect Scale (GASS)- Clozapine

| | | | | |
|---|---|---|---|---|
| **Name:** | | **Age:** | | **Sex: M / F** |
| **Date** | | | | |
| **Caffeine intake Cups of tea or coffee per day……** | | | | |
| **Has there been a recent change in your smoking habit No ☐ Yes ☐ Details below** | | | | |
| **Increase/Decrease by ……. Cigarettes per day** | | | | |

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the **end** box if you found that the side effect distressed you.



| *Over the **past week**:* | *Never* | *Once* | *A few times* | *Everyday* | *Tick this box if distressing* |
|---|---|---|---|---|---|
| 1. I felt sleepy during the day | | | | | |
| 2. I felt drugged or like a zombie | | | | | |
| 3. I felt dizzy when I stood up and/or have fainted | | | | | |
| 4. I have felt my heart beating irregularly or unusually fast | | | | | |
| 5. I have experienced jerking limbs or muscles | | | | | |
| 6. I have been drooling | | | | | |
| 7. My vision has been blurry | | | | | |
| 8. My mouth has been dry | | | | | |
| 9. I have felt like I am going to be sick or have vomited | | | | | |
| 10. I have felt gastric reflux or heartburn | | | | | |
| 11 I have had problems opening my bowels (constipation/diarrhoea) | | | | | |
| 12. I have wet the bed | | | | | |
| 13. I have been passing urine more often | | | | | |
| 14 I have been thirsty | | | | | |
| 15 I have felt more hungry than usual or have gained weight | | | | | |
| 16. I have been having sexual problems | | | | | |

| ***I have also experienced*** *(Please write down any other side effects of physical problems or complaints that you may have had over the last week)* |
|---|
| 17 |
| *18* |
| *19* |
| *20* |

### Staff Information

2. Allow the service user to fill in the questionnaire themselves, in some circumstances staff may have to support the patient to complete the assessment. Questions 1-20 relate to the previous week.

2. Scoring

For questions 1-16 award

0 points for an answer of "never".
1 point for the answer "once",
2 points for the answer "a few times"
3 points for the answer "everyday".

Total for all questions

3. For all patients a *total score* of:

*0-16* = absent/mild side effects
*17-32* = moderate side effects
*over 32* = severe side effects

4. Side effects covered by questions

*1-2* Sedation and CNS side effects
*3* *Postural hypotension*
*4* *Tachycardia*
*5* *Myoclonus*
*6* *Hypersalivation* extra-pyramidal side effects
*7-8* Anticholinergic side effects
*9-10* Gastro-intestinal side effects
*11* *Constipation/overflow*
*12* *Nocturnal enuresis*
*13-14 Screening for diabetes mellitus*
*15* weight gain
*16* *Sexual dysfunction*

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Question 17-20 invite the service user to report any other side effects or problems not already mentioned. These questions are not scored but may instigate a discussion with the service user if clinically appropriate.