British Columbia and Saskatchewan

FOR 24 HOUR REGISTRATION – ALL FIELDS MUST BE COMPLETED

PATIENT Registration

Form Completed By: ☐ Doctor ☐ Pharmacist ☐ Local Case Coordinator/Case Manager

GenCAN Gen-Clozapine ACCESS Network

Phone 1-866-501-3338
Fax 1-800-497-9592
Website www.gencan.ca

Please check one.

☐ ***Continuing*** *Treatment Patient***
(Patient is currently receiving another brand of Clozapine.)

☐ ***New*** *Patient Enrollment*

☐ *Modification*
☐ *Transferred to another brand of Clozapine*
☐ *Discontinued treatment with Clozapine*

☐ *Discharged from Hospital*
Date ____ / ____ / ____ *DD/Mon/YYYY*

Reason for Discontinuation ______________________

SECTION 1. Patient Information

If patient previously enrolled, please indicate GenCAN number: [| | | | | | | | | | | | | |]

Status: ☐ *Inpatient* ☐ *Outpatient*

Patient Initials [First | Last] *Prov.:* [|] *Prov. Health Ins. #:* [| | | | | | | | | | |] *(Optional)* *Gender:* ☐ *Male* ☐ *Female*

Date of Birth: ____ / ____ / ____ *DD/Mon/YYYY* *Race:* ☐ *Caucasian* ☐ *Black* ☐ *Asian* ☐ *Other (specify):* ______

Baseline blood result: *WBC Result:* ______ *ANC Result:* ______ *Blood Draw Date:* ____ / ____ / ____ *DD/Mon/YYYY*

For Continuing Treatment Patient only:**

Start Date on Clozapine: ____ / ____ / ____ *DD/Mon/YYYY*
(Any Brand)

Monitoring Frequency: ☐ *Weekly* ☐ *Every 2 weeks* ☐ *Every 4 weeks*

SECTION 2. Laboratory and Local Case Coordinator/Manager

Laboratory: ______ *Tel.:* (____) ______ *Fax.:* (____) ______

Case Manager: ______ *Tel.:* (____) ______ *Ext.:* ______ *Fax.:* (____) ______

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

If pharmacist previously registered, please indicate only GenCAN pharmacist ID number [| | | | | | | | |]

Pharmacist: ______ *Pharmacist License No.:* [| | | | | | | |] *Language:* ☐ *English* ☐ *French*

Pharmacy Name: ______ *Address:* ______ *City:* ______

Prov.: [|] *Postal Code:* [| | | | |] *Tel.:* (____) ______ *Ext.:* ______ *Fax.:* (____) ______

Wholesaler: ______ *Account #:* [| | | | | | | | |]

I confirm that all dispensing pharmacists at this location will only dispense Gen-Clozapine on a weekly, two-weekly or monthly basis upon confirmation that the patient has had his/her blood drawn for a Complete Blood Count and Differential (CBC and Diff.) for the current period.

Pharmacist Signature: ______ *Date:* ____ / ____ / ____ *DD/Mon/YYYY*

SECTION 4. To be completed and signed by Treating **Physician** → ☐ Lab Req. CC to GENCAN 1-800-497-9592

Physician Name: ______ *Prov. License No.:* [| | | | | | | |] *Language:* ☐ *English* ☐ *French*

Patient Treatment Location: ______ ■ *Baseline CBC & Diff. completed*

Address: ______ *City:* ______

Prov.: [|] *Postal Code:* [| | | | |] *Tel.:* (____) ______ *Ext.:* ______ *Fax.:* (____) ______

I, the treating physician, will ensure that blood testing (white blood cell count and differential) for this patient (identified above) as required by the clozapine Product Monographs is performed at the specified frequency. I understand that no pharmacy will dispense any 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. I will not prescribe clozapine until the nonrechallengeable status of this patient has been verified.

I have informed the patient and he/she has not objected and, in fact, has consented to the release of relevant personal information and safety information held within a clozapine database to 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. The safety information which may be released includes, the non-rechallengeable/hematologic status of the patient, white blood cell counts and absolute neutrophils counts, dates and other information as may be relevant to the safe treatment of the patient with clozapine. Additional relevant personal information which may be released includes patient initials, date of birth, gender, province and health care number.

I have also informed the patient of the existence of the GenCAN Privacy Policy which they may view at www.gencan.ca. In addition, they may contact Genpharm's Privacy Officer directly with questions.

Physician Signature: ______ *Date:* ____ / ____ / ____ *DD/Mon/YYYY*

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