CAMBRIDGE CLINICAL LABORATORIES

Therapeutic Drug Monitoring (TDM) Test Request Form

CLINICAL CENTRE INFORMATION

CCL Account Number		Requesting doctor	
Hospital/Clinic		QUERIES: Name	
Address		Telephone	
		Fax	
Postcode		Email	

PATIENT INFORMATION

Affix clinic label below:

	ID1:	Weight	
	ID2:	Height	
	ID3:	Viral load	
	Date of birth	CD4	

Please complete a new TRF for each sample submitted – do not include 2 time points on one request form e.g. peak and trough samples should be submitted on separate forms.

DO NOT SEND WHOLE BLOOD, IT CANNOT BE TESTED AND WILL BE REJECTED ON RECEIPT PROCESS TO PLASMA ASAP AND <4 HOURS AFTER VENESECTION.

SAMPLE TO BE TESTED

Plasma ONLY	***Li-Hep*** ☐ ***EDTA*** ☐	**Date Taken**		**Time Taken**	

Constituent drug(s) to be analysed *	Dose (mg)	Tick if with ritonavir	Tick dosing frequency				Time elapsed since last dose
			OD ☐	*BD equal* ☐	*BD unequal* ☐	*Other* ☐	H MIN
			OD ☐	*BD equal* ☐	*BD unequal* ☐	*Other* ☐	H MIN
			OD ☐	*BD equal* ☐	*BD unequal* ☐	*Other* ☐	H MIN
			OD ☐	*BD equal* ☐	*BD unequal* ☐	*Other* ☐	H MIN
			OD ☐	*BD equal* ☐	*BD unequal* ☐	*Other* ☐	H MIN

***If the patient is on a fixed dose combination therapy e.g. *Atripla*, please list the constituent drugs you wish to be analysed in the table above e.g *Efavirenz, Tenofovir and FTC*. If you list only the combination therapy then all the inclusive drugs will be tested.**

OTHER ANTIRETROVIRAL THERAPY

REASON FOR TDM *(tick more than one if applicable)*

Pregnancy	☐	Paediatric	☐	Possible Drug Interaction	☐	Liver Failure	☐	Suspected Toxicity	☐
Dialysis	☐	Renal Failure	☐	Suspected Treatment Failure	☐	Inpatient/ITU	☐	Other	☐

ADDITIONAL COMMENTS

CCL USE ONLY CCL ID No ..... Date..... Entered by..... Validated by.....

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