Antiepileptic Drug Level (Concentration) Request Form

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Report & Invoice address:

Purchase Order No:

Clinical Details:				Surname:		First Name:	
Sex: M/F DoB: NHS □ PP □				Hospital number:		NHS number:	
Other current drug therapy:				Location/Ward/House:			
				Consultant:		Requested by:	
Reason for Request (tick √)				Date of Request:		Signature:	
Compliance □ Suspected drug interaction □				Sample Information (tick √)			
Suspected toxicity □ Lack of effect □				Sample type: plasma □ serum □ saliva □ other (specify) □			
Pregnancy □ Urgent □ Routine □				Last dose (date): at hrs (24 h clock)			
Drug	Tick √	Daily dose (mg)	Level	Blood drawn (date): at hrs (24 h clock)			
Brivaracetam				Drug	Tick √	Daily dose (mg)	Level
Carbamazepine				Perampanel			
CBZ-epoxide				Phenobarbitone			
Clobazam				Phenytoin			
Clonazepam				Pregabalin			
Eslicarbazepine				Primidone			
Ethosuximide				Rufinamide			
Felbamate				Stiripentol			
Gabapentin				Tiagabine			
Lacosamide				Topiramate			
Lamotrigine				Valproic acid			
Levetiracetam				Vigabatrin			
Oxcarbazepine				Zonisamide			