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Clinical information form
Antiarrhythmics

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PATIENT

Last name: .....

Name: .....

Birth name: .....

Date of birth: |__|__|__|__|__|__|__|__|

Gender: ☐ F ☐ M

UF LABEL REQUESTING DEPARTMENT

PRESCRIBING DOCTOR

Last name: .....

Service: .....

Address: .....

PC: |__|__|__|__|__| City: .....

Tel. : |__|__|__|__|__|__|__|__|__|__|

E-mail: .....

Research and/or dosage of: .....
.....

REASON FOR REQUEST

☐ Monitoring ☐ Overdose - Undesirable effects ☐ Suspected drug interaction

☐ Inefficiency ☐ Suspicion of non-compliance ☐ Other: .....

DOSAGE AND ADMINISTRATION

☐ Per os (= Oral administration): ..... mg morning, ... mg midday, ... mg evening

☐ Intra-muscular (describe dose and administration schedule): .....

☐ Intravenous Continuous (IVSE , SAP): mg/24h

☐ Discontinuous (sequential or infusion: describe dose and administration schedule): .....
.....

Date and time of last dose: |__|__|__|__|__|__|__|__| at |__|__| h |__|__| min.
Date and time of sampling: |__|__|__|__|__|__|__|__| at |__|__| h |__|__| min.

Lab label

ASSOCIATED TREATMENTS

☐ Monitoring ☐ Associated treatments unknown

☐ Yes (list): .....

OTHER CLINICAL INFORMATION

Renal insufficiency: ☐ YES ☐ NO ☐ N/A Creatinine levels: .....

Dialysis: ☐ YES ☐ NO ☐ N/A Clearance: .....

Liver failure: ☐ YES ☐ NO ☐ N/A

Severe hypoalbuminemia: ☐ YES ☐ NO ☐ N/A

These analyses are transmitted as part of a partnership with Lille University Hospital

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