



# NIZAM'S INSTITUTE OF MEDICAL SCIENCES

(A UNIVERSITY ESTABLISHED UNDER STATE ACT)

040-23489000/9244 – 040-23396552  
Fax: 040-23310076  
Panjagutta, Hyderabad-500082, Telangana  
www.nims.edu.in

## **DEPARTMENT OF CLINICAL PHARMACOLOGY AND THERAPEUTICS** **REQUISITION FOR WHOLE BLOOD CYCLOSPORINE / TACROLIMUS / MMF/EVEROLIMUS**

Patient's Name ..... IP / OP No..... Date:.....

Ref. by Dr ..... Phone. No. .... Lab No : .....

AGE/Gender.....Wt .....Ht.....Paying / Free.....Ward.....

### REASONS FOR REQUEST :

Suspected Toxicity : Yes / No : Compliance : Yes / No.

Therapeutic confirmation : Yes /No Less or no Therapeutic response : Yes / No

Date of Transplant Surgery Done .....

Blood Urea ....., S. Creatinine.....(At the time of Surgery)

Present Cyclosporine/Tacrolimus/MMF/Everolimus Dose ...../day

Duration with present dose (in months) .....

Last Dose : Date ..... Time .....AM / PM

Sample collection : Date ..... Time .....AM / PM

Additional Information (Latest) : Date : .....

1. Blood Urea : ..... S.Creatinine .....mg/dl; Any other: .....

2. Does the patient suffer from diarrhea? Yes / No

### CONCOMITANT DRUG THERAPY :

NAME OF THE DRUG	DOSE	DURATION
------------------	------	----------

**Note : Please collect 3 ml blood in EDTA vacutainer**

**Lab Telephone No: 040-23489212/040-23489351**

\*\*\* Dr P Usha Rani \*\*\*