GASS for Clozapine

Name: _____ **Current Medications:** _____

Date: _____ _____

Caffeine intake: **…….cups/day** _____ _____

Smoker: Y / N **…….cigarettes/day** _____ _____

Has there been a recent change in your smoking habit?: **Increase/Decrease by……cigarettes/day**

This questionnaire is being used to determine if you are suffering from excessive side effects from your medication.
Please put a tick in the column which best indicates how often or how severely you have experienced the following side effects.

Over the **past week**:		Never	Once	A few times	Everyday	Tick if severe or distressing
1	I felt sleepy during the day					
2	I felt drugged or like a zombie					
3	I felt dizzy when I stood up or have fainted					
4	I have felt my heart beating irregularly or unusually fast					
5	I have experienced jerking limbs or muscles					
6	I have been drooling					
7	My vision has been blurry					
8	My mouth has been dry					
9	I have felt sick (nauseous) or have vomited					
10	I have felt gastric reflux or heartburn					
11	I have had problems opening my bowels (constipation)					
12	I have wet the bed					
13	I have been passing urine more often					
14	I have been thirsty					
15	I have felt more hungry than usual or have gained weight					
16	I have been having sexual problems					

I have also experienced: (please write down any other side effects **OR PHYSICAL PROBLEMS OR COMPLAINTS** that you may have experienced over the past week)	
17	
18	
19	
20	

Hynes, C. *et al.* (2015) "Glasgow Antipsychotic Side-effects Scale for Clozapine — Development and validation of a clozapine-specific side-effects scale," *Schizophrenia research*, 168(1–2), pp. 505–513. Glasgow Antipsychotic Side-effects Scale for Clozapine - Development and validation of a clozapine-specific side-effects scale - PubMed

Staff Information

1. Allow the service user to fill in the side-effects scale themselves. All questions relate to the previous week

2. **Scoring**

0 Points	"Never"
1 point	"Once"
2 points	"A few times"
3 points	"Everyday"

3. **Results**

0-16	absent/mild side-effects
17-32	moderate side-effects
33-48	severe side-effects

4. **Side-effects covered include:**

1-2	Drowsiness and sedation
3	Postural hypotension
4	Tachycardia
5	Myoclonus
6	Hypersalivation
7-8	Anticholinergic side-effects
9-10	Gastrointestinal side-effects
11	Constipation
12	Nocturnal enuresis
13-14	Screening for diabetes mellitus
15	Weight gain
16	Sexual dysfunction

5. The column relating to the severity/distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

6. Questions 17 to 20 invite the service user to report any other side-effects or problems not already mentioned. These questions should not be scored but may instigate a discussion with the service user if clinically appropriate.

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