



LITHIUM MONITORING CHECKLIST

Patient Name _____

Patient DOB _____

MPRN _____ Consultant _____

Initial Checks

Verbal information regarding benefits, risks and monitoring

Decision Support Person present

Patient given Info Booklet

Date _____

Ask About

Bloods Date _____	Urea <input type="checkbox"/>	Height: _____	Date _____
	Creatinine <input type="checkbox"/>	Weight: _____	
	eGFR <input type="checkbox"/>	BMI: _____	
	Sodium <input type="checkbox"/>	ECG Normal <input type="checkbox"/>	Date _____
	Potassium <input type="checkbox"/>	ECG Abnormal: <input type="checkbox"/>	
	Adjusted Calcium <input type="checkbox"/>	Pregnant <input type="checkbox"/>	
	Thyroid Stimulating Hormone <input type="checkbox"/>	Family Planning <input type="checkbox"/>	
	Free T4 <input type="checkbox"/>	Record Contraception: _____	
	FBC <input type="checkbox"/>		

Prior to starting lithium

Side effects of Lithium Polyuria Polydipsia Lethargy Fine tremor Gastrointestinal upset Dry Mouth

Record

<p>Signs of Toxicity?</p> <p>Tremor Slurred speech</p> <p>Paraesthesia Anorexia</p> <p>Ataxia Nausea Confusion</p> <p>Diarrhoea Blurred vision</p> <p>Sedation Muscle Weakness</p>	<p>Acute illness?</p> <p>Dehydration / Febrile</p> <p>Vomiting/Diarrhoea</p> <p>Surgery/Trauma</p> <p>Cardiac Event</p> <p>Electrolyte disturbance</p> <p>Pregnancy / Breastfeeding</p>
<p>Comorbidities (e.g. Renal Impairment)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Drug interactions (e.g. Thiazides, NSAIDs, ACEIs/ARBs)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Every Review

On Initiation/ Addition
Change/Discontinuation of
interacting medicine

Lithium trough (12h post dose) 5-7 days after dose change

Repeat ECG as clinically indicated (if abnormal)

Patient preference for routine monitoring

Every 3 months

Lithium trough (12h post dose)

Urea, Creatinine, eGFR, Na, K+

CMHT

Every 6 months

TSH, Free T4, Corrected Calcium

GP

Every 12 months

Height, weight, BMI, Blood Pressure

Lipids, Plasma Glucose, HbA1C

Repeat ECG as clinically indicated

Letter Sent

Date _____

Routine Monitoring

To be completed by a medical practitioner

Signature

Date