ST. JOSEPH'S HEALTHCARE HAMILTON MAB CLINIC REFERRAL FORM

Patient Information

Name: _____ **Sex: M / F** ☐ ☐ **Date of birth:** _____

Allergies: _____

Address: _____ **City/Prov:** _____ **/** _____

Postal: _____ **Phone:** _____ **HCN:** _____

NOTE: For patients with mild COVID-19 with confirmed COVID-19. These products are available for use under an interim authorization (Interim Order) by Health Canada to prevent progression of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) who are at high risk for progression to severe COVID-19, including hospitalization or death.

In order to qualify for therapy, patients need to a) Be symptomatic b) Be within 7 days of symptom onset c) Meet 1 criteria under vaccinated or unvaccinated d) Be willing to travel to the clinic to receive therapy e) Expected survival > 1 year from all causes

Criteria for Use (all fields must be completed to be eligible for treatment)

- ❑ **Date of symptom onset:** _____ Treatment must be given within 7 days of symptom onset.
- ❑ **Symptoms:** _____
- ❑ **Date of positive COVID-19 test:** _____
- ❑ **Does this person have a history of prior COVID-19 within the past 90 days?**
- ❑ **Has this person received at least one dose of vaccine ?**

☐ Yes – do they meet any of the following criteria?

- ☐ Hematologic malignancy or Bone Marrow Transplant (Please specify: _____)
- ☐ Solid Organ Transplant (Please specify: _____)
- ☐ Significant immunosuppression (Please indicate type: high-dose corticosteroids > 2 weeks, alkylating agents, antimetabolites, cance chemotherapy, TNF blockers, anti-CD20 agents and other immunosuppressive biologic agents)
- ☐ Primary immunodeficiency (Please specify: _____)
- ☐ Advanced or untreated HIV
- ☐ Age >=70 AND single medical condition listed in the unvaccinated criteria below: Specify: _____
- ☐ Age >=50 AND first nations/Inuit/metis AND single medical condition in the unvaccinated criteria below: Specify: _____

☐ No – do they meet any of the following criteria?

- ☐ Age >= 60
- ☐ Indigenous (First Nations, Inuit, or Métis)
- ☐ Obesity (BMI > 35)
- ☐ Cardiovascular Disease (Excluding Hypertension) (Please Specify: _____)
- ☐ Chronic Lung Disease (Excluding Mild Asthma not on ICS) (Please specify: _____)
- ☐ Diabetes Mellitus
- ☐ Chronic Kidney Disease (GFR < 30)
- ☐ Chronic Liver Disease with Cirrhosis
- ☐ Immunosuppressed or on Immunosuppressants (Please Specify: _____)
- ☐ Pregnancy
- ☐ Sickle Cell Disease
- ☐ Intellectual disability
- ☐ Cerebral Palsy

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Prescriber Attestation (Must be checked to be eligible for treatment)

☐ I affirm that my patient meets above criteria for use

Prescriber Name (print): _____ Direct Contact Number (not office line): _____

Prescriber Fax number: _____

Prescriber Signature: _____ Date/Time: 04/Jan/2022 15:51 College #: _____

St Joseph's Healthcare Hamilton – Fax to 905-522-4469
Phone: 905-522-1155 x 34012