

Referral Form - For sites offering multiple antiviral treatments

Patient Information															
Name: _____ Date of birth: _____ Allergies: _____															
Address: _____ City/Prov: _____ / _____															
Postal: _____ Phone: _____ HCN: _____															
<p>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 (18 years of age and older who are at high risk for progression to severe COVID-19, including hospitalization or death).</p> <p>In order to qualify for therapy, patients need to a) Be symptomatic b) Be within 5-7 days of symptom onset c) Fulfil either criteria 1, 2 OR 3 d) Be willing to receive therapy. All providers can prescribe paxlovid as of April 12, 2022. Patients should be referred only if this is not an option. Patients will be prioritized if they are higher risk (5% or higher risk of hospitalization)</p>															
Criteria for Use (all fields must be completed to be eligible for treatment)															
<input type="checkbox"/> Date of symptom onset: _____ <input type="checkbox"/> Date of positive COVID-19 test: _____ <input type="checkbox"/> Current Medications: _____ <input type="checkbox"/> Recent Creatinine and AST/ALT if available (within 3 months) _____ <input type="checkbox"/> CRITERIA 1: Immune suppressed (regardless of vaccine status)															
<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> Treatment of Solid Organ Cancer</td> <td style="width:33%; border: none;"><input type="checkbox"/> Lymphoma</td> <td style="width:33%; border: none;"><input type="checkbox"/> Hematologic malignancy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Receipt of CAR-T therapy</td> <td style="border: none;"><input type="checkbox"/> Bone Marrow Transplant</td> <td style="border: none;"><input type="checkbox"/> Solid Organ Transplant</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Congenital Immunodeficiency (please specify)</td> <td style="border: none;"><input type="checkbox"/> Corticosteroids (> 20mg prednisone per day for > 2 weeks)</td> <td style="border: none;"><input type="checkbox"/> Oral immunosuppressive agents: (please specify)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Biologic agents (Please specify)</td> <td colspan="2" style="border: none;"><input type="checkbox"/> Untreated or advanced HIV</td> </tr> </table>				<input type="checkbox"/> Treatment of Solid Organ Cancer	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Hematologic malignancy	<input type="checkbox"/> Receipt of CAR-T therapy	<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> Solid Organ Transplant	<input type="checkbox"/> Congenital Immunodeficiency (please specify)	<input type="checkbox"/> Corticosteroids (> 20mg prednisone per day for > 2 weeks)	<input type="checkbox"/> Oral immunosuppressive agents: (please specify)	<input type="checkbox"/> Biologic agents (Please specify)	<input type="checkbox"/> Untreated or advanced HIV	
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<input type="checkbox"/> CRITERIA 2: Does this individual have risk factors AND vaccine status that fits criteria below? (please check risk factors in a) and fill out table b if patient meets criteria)															
a) Risk Factors – please check all that all that apply															
<input type="checkbox"/> Obesity	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Kidney Disease (EGFR < 60)	<input type="checkbox"/> Pregnancy (ONLY UNVACCINATED)												
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Liver Disease (CP class B/C)													
<input type="checkbox"/> Heart Disease (HTN, CHF, CAD)	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Respiratory Disease													
b) Vaccine Status and Risk factors (Please check if the patient fits an eligible category)															
Age	Number of Vaccine Doses														
	0 doses	1-2 doses	3-4 doses												
<18	<input type="checkbox"/> Eligible if 1 or more risk factors	<input type="checkbox"/> Eligible if 1 or more risk factor	Not eligible												
18-59	<input type="checkbox"/> Eligible if 1 or more risk factors	<input type="checkbox"/> Eligible if 1 or more risk factor	Not eligible												
60-69	<input type="checkbox"/> Eligible	<input type="checkbox"/> Eligible	Not eligible												
>70	<input type="checkbox"/> Eligible	<input type="checkbox"/> Eligible	<input type="checkbox"/> Eligible												
<input type="checkbox"/> CRITERIA 3: Patient has another high-risk condition that puts them at risk of deterioration not listed above, where treatment may be warranted. Please Specify: _____															
Referral Attestation (Must be checked to be eligible for treatment)															
<input type="checkbox"/> I affirm that my patient meets above criteria for use															
Clinician Name (print): _____ Direct Contact Number _____ Clinician Signature: _____ Date/Time: _____ / _____ College #: _____															

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Regional sites offering Remdesivir and Paxlovid (walk-in not accepted):

- Health Sciences North – COVID Assessment Centre, 2050 Regent St, Sudbury, **Fax: 705-523-4464**
- Humber River Hospital – Finch RCC, COVID Assessment Centre, 2111 Finch Ave W, North York, **Email: CACfinch@hrh.ca**
- The Ottawa Hospital – Civic Campus, 1052 Carling Ave, Ottawa, **Fax: 613-739-6751**
- Scarborough Health Network – Centenary Hospital, 2867 Ellesmere Rd, Scarborough, **Fax: 416-281-7384**
- St. Joseph’s Healthcare Hamilton – ED Entrance, 50 Charlton Ave East, Hamilton, **Fax: 905-522-4469**
- Thunder Bay Regional Health Sciences Centre – 984 Oliver Rd, Suite 101, Thunder Bay, **Fax: 807-623-6631**, Tele: 807-935-8101
- Windsor Regional Hospital – 1030 Ouellette Ave, Windsor, **Email: WRHmAbclinic@wrh.on.ca**