Trillium Health Partners
Better Together

Covid-19 Treatment Referral

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

Patient Information

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Allergies: _____

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).

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)

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

- ❑ **Date of symptom onset:**_____
- ❑ **Date of positive COVID-19 test:** _____
- ❑ **Current Medications:** _____
- ❑ **Recent Creatinine and AST/ALT if available (within 3 months)**_____
- ❑ **CRITERIA 1: Immune suppressed (regardless of vaccine status)**

❑ **Treatment of Solid Organ Cancer**	❑ **Lymphoma**	❑ **Hematologic malignancy**
❑ **Receipt of CAR-T therapy**	❑ **Bone Marrow Transplant**	❑ **Solid Organ Transplant**
❑ **Congenital Immunodeficiency (please specify)**	❑ **Corticosteroids (> 20mg prednisone per day for > 2 weeks)**	❑ **Oral immunosuppressive agents: (please specify)**
❑ **Biologic agents (Please specify)**	❑ **Untreated or advanced HIV**	

❑ **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

❑ **Obesity**	❑ **Cerebral Palsy**	❑ **Kidney Disease (EGFR < 60)**	❑ **Pregnancy (ONLY UNVACCINATED)**
❑ **Diabetes**	❑ **Intellectual Disability**	❑ **Liver Disease (CP class B/C)**	
❑ **Heart Disease (HTN, CHF, CAD)**	❑ **Sickle Cell Disease**	❑ **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	❑ Eligible if 1 or more risk factors	❑ Eligible if 1 or more risk factor	Not eligible
18-59	❑ Eligible if 1 of more risk factors	❑ Eligible if 1 or more risk factor	Not eligible
60-69	❑ Eligible	❑ Eligible	Not eligible
>70	❑ Eligible	❑ Eligible	❑ Eligible

❑ **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: _____

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Referral Attestation (Must be checked to be eligible for treatment)	
❑ I affirm that my patient meets above criteria for use	

Name of Referring Provider (Last Name, First Name- as listed in College): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ College/CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____

Location:

- Trillium Health Partners COVID-19 Therapeutics Clinic at the Queensway Health Centre
- Address: 150 Sherway Drive, Level 1, Etobicoke

Next Steps:

- Please fax referral to THP at 416-521-4082
- Inform patient that if they are eligible and the treatment is available, they will receive a call from the COVID-19 Therapeutics Clinic to book the appointment
- Note: The clinic is by appointment only
- If the patient is <u>not</u> booked, the referring clinician will receive a fax notification that the treatment was not given