Date:_____

Hasbro Children's Hospital & the Tomorrow Fund Clinic

MAB-INTAKE REFERRAL

Phone: 401-444-8630 Fax: 401-444-5650

Basic Demographic Information

Patient Name _____ DOB _____

Aged _____ Preferred Language _____ Phone #_____

Referred by _____

Referring Provider's Best Phone # _____

I have discussed treatment with parent(s), and they want to pursue treatment YES NO

Does the patient have transportation? YES NO

Has the provider reviewed FDA EUA Regeneron with the parent(s)? YES NO

COVID-19 Related Information

Date of symptom onset_____ Date of positive test for SARS-CoV2 _____

OR date of COVID-19 exposure _____

Is the patient on home oxygen at baseline? YES NO

- If YES, what is the patient baseline oxygen requirement _____ L/min
- If YES, what is the patient's current oxygen need? _____None (room air) _____L/ min

Weight _____ Height _____ Is BMI percentile >85% YES NO

Is the patient pregnant? YES NO

Allergies _____

Other risk factors? _____