Lifespan
Delivering health with care.™

MONOCLONAL ANTIBODY FOR TREATMENT OF SARS-COV-2 REFERRAL FORM

Dear Provider: Thank you for referring your patient to receive a monoclonal antibody ***for treatment of COVID-19****. Monoclonal antibodies are authorized under FDA Emergency Use Authorization (EUA). Please supply the following information for our team to be able to assess your referral. Final determination of which monoclonal antibody your patient receives will be determined by our team.*
Please fax this form to Lifespan at 401-793-7659

BASIC DEMOGRAPHIC INFORMATION

Patient Name: ____ Date of Birth: _____________ Age: _________

Gender: ____________ Preferred Language: _________________ Phone: ________________________________

Address: ____

Contact Person for Scheduling (if different from patient): ______________________ Phone: ____________________

Patient Accessibility: Ambulatory Requires wheelchair Requires Stretcher

Referring Provider's Name: ____ NPI No.: _____________________

Referring Provider's Phone Number: _____________________ Referring Provider's Fax Number: __________________

Referring Provider's Address: ____

COVID-19 RELATED INFORMATION

Date of symptom onset: ________________ Date of positive COVID-19 test: _______________

Is the patient on home oxygen on baseline: Yes No

If yes, what is the patient's baseline oxygen requirement? ________ L/min

What is the patient's current oxygen requirement? ______ L/min None (room air)

High-Risk Criteria: **(required)**
Patient is at high risk for progression to severe COVID-19, including hospitalization or death (refer to CDC website or see list on page 2)

RELEVANT MEDICAL HISTORY

Patient's Weight (kg): ____________ Patient's Height (inches): _______________ BMI: ___________

Current Medications: ____

Allergies: ____

Past Medical History: ____

Is the patient pregnant? Yes No

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Please check if patient has any of the following risk factors for severe illness:

- Age ≥ 65
- Overweight or Obesity (BMI ≥ 25 kg/m^2)
- Cardiovascular disease
- Cerebrovascular disease
- Hypertension
- Chronic obstructive pulmonary disease or other chronic lung disease
- Chronic kidney disease
- Chronic liver disease
- Diabetes
- Immunosuppressive disease
- Use of immunosuppressive agents
- Dementia or other neurological condition
- Sickle cell disease or thalassemia
- Mental health conditions
- Smoking, current or former
- Substance use disorder
- Racial or ethnic minority group
- Other risk factors for severe illness: ____

ORDERING PROVIDER DECLARATION

Whether provided in person or virtually, I confirm that this patient or legal representative has received a full explanation about the nature and purpose of monoclonal antibody treatment, the risks involved in receiving monoclonal antibody treatment, and treatment alternatives. The patient confirms they have received answers to all questions, and to the best of my knowledge, I believe patients has been adequately informed and consented.

Counseling Requirements: **(must select all for eligibility)**

- Ordering Provider has reviewed the FDA EUA with patient/caregiver and has:
- Provided the "Fact Sheet for Patient, Parents and Caregivers," (casirivimab/imdevimab, bamlanivimab/etesevimab, or sotrovimab) **AND**
- Informed patient/caregiver of alternatives to receiving a monoclonal antibody for treatment of COVID-19, **AND**
- Informed patient/caregiver monoclonal antibodies for treatment of COVID-19 are unapproved drugs that are authorized for use under EUA

Provider's Declaration Signature: __________________________ Date: _____________ Time: ______________