|  |
| --- |
| **Patient Information** |
| **Name: 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 (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 3d) 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 at 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:**
* **Community Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **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)**
1. **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**
 |

1. **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 or social determinants of health that put them at increased risk of disease progression, where treatment may be warranted. Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Referral Attestation** (Must be checked to be eligible for treatment) |
| * I affirm that my patient meets above criteria for use
 |  |
| Clinician Name (print): Direct Contact Number \_\_\_\_\_ Clinician Signature: Date/Time: / College #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**COVID-19 Treatment\* Referral**

Fax Received:

Date/Time:

\*Each site will advise on product availability

Regional sites offering COVID-19 antiviral treatment (walk-in not accepted):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * AGH 807-597-1210
 | ▢ | DRHC 807-223-8843 | ▢ | SLMHC 807-737-5271 |
| * RHCF 807-274-4839
 | ▢ | NOSH–Wilson 807-229-0847 | ▢ | SJCG Homes 807-345-0230 |
| * LWDC 807-468-3351
 | ▢ | GDH 807-854-4202 | ▢ | TBRHSC Assessment Centre Fax: 807-623-6631Tele: 807-935-8101  |
| * RLMCMH 807-727-2217
 | ▢ | NDHC 807-887-3393 | ▢ | Other Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |