Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Verification:**

I have evaluated the patient identified herein and reviewed the lab results provided. This patient has at least one Risk factor, documented Positive PCR or Antigen test for Covid-19, and Negative antibody test for Covid 19.

Antibody positive or negative \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ **Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If more than one calendar day, repeat)

PCR positive or negative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antigen positive or negative\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Risk Factors – Please check all that apply

|  |  |
| --- | --- |
|  | **All patients who meet at least 1 of the following**  |
|  | Age ≥ 65 years of age |
|  | BMI ≥ 35  |
|  | Chronic kidney disease  |
|  | Diabetes  |
|  | Immunosuppressive disease  |
|  | Receiving immunosuppressive treatment  |

|  |  |
| --- | --- |
|  | **Patients ≥ 55 years of age AND have any of the following**  |
|  | Cardiovascular disease  |
|  | Hypertension  |
|  | COPD or other chronic respiratory disease  |

|  |  |
| --- | --- |
|  | **Adolescents (12-17 years of age) who meet at least 1 of the following**  |
|  | BMI ≥85th percentile for age/gender |
|  | Sickle cell disease |
|  | Congenital or acquired heart disease |
|  | Neurodevelopmental disorders (e.g. cerebral palsy) |
|  | Asthma, reactive airway, or other chronic respiratory disease that requires daily medication for control |
|  | Medical-related technological dependence [e.g., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)]  |

 Based on these findings the patient **IS** a candidate for Monoclonal Antibody Therapy.

 Based on these findings the patient **IS NOT** a candidate for Monoclonal Antibody Therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of provider Date and time

**Consent for Treatment**

I have been educated on the indications, potential risks and benefits of Monoclonal Antibody therapy for COVID-19.

I have had the opportunity to ask questions related to this therapy and I consent to treatment with Monoclonal Antibody.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or legal guardian if minor Date/Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature or signature of legal guardian if minor