ONTARIO HEALTH WEST COVID ASSESSMENT CENTRE: Outpatient COVID Therapy Referral Form
MUST include accurate medication list with Form

Please fax completed form AND patient's medication list to clinic

PATIENT INFORMATION

First Name	**Last Name**	**Sex (at birth)** ☐ Male ☐ Female	**DOB**
Address	**City**	**Health Card No.**	**Version**
Postal Code	**Telephone**	**Preferred Language** ☐ EN ☐ Other	
Allergies		**Height (cm)**	**Weight (Kg)**

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 and pediatric patients (12 years of age and older weighing at least 40 kg) who are at high risk for progression to severe COVID-19, including hospitalization or death. **Please check current patient eligibility here:** https://covid-19.ontario.ca/covid-19-antiviral-treatment

Nirmatrelvir-Ritonavir (Paxlovid™) is available through community physicians in association with pharmacies across Ontario https://covid-19.ontario.ca/covid-19-treatments**). The Paxlovid Prescription form can be accessed** https://ehealthce.ca/COVID-Therapeutics.htm**.**

REASON FOR REFERRAL

THIS REFERRAL FORM SHOULD ONLY BE USED TO REFER PATIENTS WHO REQUIRE SPECIALIZED CARE FOR THE FOLLOWING REASONS (PLEASE SELECT ALL THAT APPLY):

- ❑ Patient has no access to a provider within 5 days
- ❑ Patient is medically complex and has significant drug interactions (Please specify:_____)
- ❑ Patient requires IV Remdesivir (note this requires 3 consecutive days of on-site intravenous infusions):
  - ☐ Solid Organ Transplant ☐ EGFR < 30 ☐ Pregnant
- ❑ Other: Please specify: _____

INCLUSION CRITERIA: MUST MEET CRITERIA TO PROCEED WITH TREATMENT

Date of symptom onset (Day 0) - must be 7 days or less: _____ **Positive COVID Test Completed (indicate test and date):**

☐ PCR Date: _____ ☐ Self-Administered RAT Date: _____ ☐ Health Care Administered RAT Date:_____ ☐ ID NOW:_____

AGE (YEARS)	NUMBER OF VACCINE DOSES	
	0, 1, OR 2 DOSES	3 DOSES
18 to 59	❑ Eligible if 1 or more risk factors	Not eligible
60 to 69	❑ Eligible	Not Eligible
70 or greater	❑ Eligible	❑ Eligible
Immunocompromised individuals of any age (18 years of age and older)	❑ **Eligible: Therapeutics should always be recommended for immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying immune status, regardless of age or vaccine status.**	
Pregnancy	0 DOSES	1,2, or 3 DOSES
	❑ Eligible	Not Eligible

Indigenous persons (First Nations, Inuit, or Métis), Black persons, and members of other racialized communities may be at high risk of disease progression due to disparate rates of comorbidity, increased vaccination barriers, and social determinants of health, and should be considered priority populations for access to COVID-19 therapeutics.

Risk Factors: (Check all that applies)

- ☐ Obesity (BMI greater than or equal to 30 kg/m^2)
- ☐ Diabetes
- ☐ Heart disease, hypertension, congestive heart failure
- ☐ Chronic respiratory disease, including cystic fibrosis
- ☐ Cerebral palsy
- ☐ Intellectual disability
- ☐ Sickle cell disease
- ☐ Moderate or severe kidney disease (eGFR less than 60 ml/min)
- ☐ Moderate or severe liver disease (e.g. Child-Pugh Class B or C)

*** Evidence for less than 18 years of age is limited. Multidisciplinary consultation with infectious diseases and primary care is recommended**

Immunocompromise Factors: (Check all that applies)

- ☐ Solid organ or bone marrow transplant **(*)**
- ☐ CAR T-cell therapy
- ☐ Anti-CD 20 agent
- ☐ Alkylating agents, anti-metabolites **(*)**
- ☐ Advanced or untreated HIV
- ☐ Congenital immunodeficiency
- ☐ Anti-TNF blockers or other biologic agents **(*)**
- ☐ Taking chronic oral corticosteroid (greater than 20mg/d prednisone equivalent for greater than 2 weeks)
- ☐ Other: Name of Immune modifying Drug_____

(*) Depending on absolute contraindications

Note: These individuals should have a reasonable expectation for 1-year survival prior to SARS-COV-2 infection

Outpatient COVID Therapy Assessment:

- ☐ Attach current medication, herbal, OTC list
- Patient's Home Pharmacy Contact: _____
- Is the patient pregnant? ☐ YES ☐ NO ☐ N/A
- Existing liver impairment: ☐ YES ☐ NO ☐ UNKNOWN
- Existing renal impairment: ☐ YES ☐ NO ☐ UNKNOWN
  - If YES, enter Serum Creatinine and eGFR
  - ❑ Serum Creatinine (µmol/L):_____ Date:_____
  - ❑ eGFR (ml/min): _____ Date:_____

Referral Attestation (Must be checked to be eligible for treatment)

☐ **I affirm that my patient meets above criteria for use and that current medication list is included with referral**

Provider Name (print): _____

Direct Contact Number (not office line): _____ Provider Fax number: _____

College Number: _____ Signature: _____ Date: _____