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Monoclonal Antibody Infusion Referral Form

Patient Name: _____ Date of Birth _____

Patient Phone _____

Referring Provider: _____

Referring Provider Phone: _____

Referring Provider
Address:_____

Provider has reviewed FDA EUA with patient (Bamlanivimab and Etesevimab)

Yes_____ No_____

Covid 19 related information:

Date of symptom onset: _____ Date of most recent positive test: _____

Is patient on home oxygen: Yes_____ No _____

If yes, what is the patient's baseline oxygen requirement _____L/min

Patient Name:_____

Relevant Medical History:

Patient's weight: _____ Patient's height: _____

Medications:

_____
_____

Allergies:

_____

Relevant Medical History:

_____
_____
_____

Please check if patient has a history of any of the following:

_____Age greater than or equal to 65

_____Body Mass Index (BMI) greater than or equal to 35

_____Cardiovascular disease

_____Hypertension

_____Chronic obstructive pulmonary disease or other chronic lung disease

_____Chronic kidney disease

_____Diabetes

_____Immunosuppressive disease / use of immunosuppressive agents

Fax completed form to 401.886.6002