COVID-19 IV Antiviral Outpatient & Personal Care Home Treatment Referral Form

Patient Information

Name: _____ **Sex:** ☐ **M** ☐ **F** ☐ **Other** **Date of birth(D/M/Y):** _____

Allergies: _____ **PHIN:** _____

Address: _____ **City/Prov:** _____/_____

Postal code: _____ **Primary Phone:** _____ **Alternate Phone:** _____

Facility (if patient is in a long care facility/personal care home):_____

Does the Individual self-identify as Indigenous*?
** Indigenous includes people who identify as First Nations, Métis or Inuit (Note: this information is being collected to aid in surveillance and monitoring only).*

☐ **First Nations** ☐ **Métis** ☐ **Inuit** ☐ **Does not self-identify as indigenous / Declined to answer**

SECTION A – SCREENING ELIGIBITY FOR COVID-19 IV ANTIVIRAL TREAMENT

Criteria for Use (Patient must meet minimum requirements AND one of five additional criteria). **Applicable to individuals in the community as well patients in hospital and residents in PCH.**

Minimum Requirements:

- ☐ 18 years of age or older
- ☐ Symptom onset within last 7 days. Date of symptom onset (D/M/Y) _____
- ☐ Positive COVID-19 test: Specify type and date test performed (D/M/Y) _____
  - ☐ PCR
  - ☐ Rapid Test Performed by Health Care Provider
  - ☐ Rapid Test Self Administered (Test to be repeated by a care provider prior to prescribing if below criteria are met)
- ☐ Mild to moderate symptoms (Do not require supplemental oxygen (above their baseline), intravenous fluids, or physiologic support; hospital admission or referral to emergency department for COVID-19 evaluation for hospital admission NOT imminently required)

Group 1 Criteria: Immunocompromised individuals

- ☐ 18 years or older

AND have **<u>one or more of the following</u>** conditions (please check all that apply):

- ☐ Active treatment for solid tumor and hematologic malignancies, specify diagnosis_____
- ☐ Receipt of solid-organ transplant and taking immunosuppressive therapy, specify organ_____
- ☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive
- ☐ Tumor-necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

If Group One Criteria met, referral is complete, sign and fax as per below. Otherwise, proceed to Group Two.

Group 2 Criteria (all 3 must be met):

- ☐ Unvaccinated (zero doses) or partially vaccinated (1 dose of a 2-dose series)
- ☐ No history of a test confirmed COVID-19 infection in the last 6 months
- ☐ >40 years or older

If ALL Group Two Criteria met, referral is complete, sign and fax as per below. Otherwise, proceed to Group Three

---

Group 3 Criteria (all 3 criteria plus one risk factor required)

- ☐ Unvaccinated (zero doses) or partially vaccinated (1 dose of a 2-dose series)
- ☐ No history of a test confirmed COVID-19 infection in the last 6 months
- ☐ 18-40 years old

AND have **<u>one or more of the following</u>** conditions (please check all that apply):

- ☐ Diabetes (diet controlled, insulin, non-insulin)
- ☐ Smoking (current or previous)
- ☐ BMI >30: Height _____(inches/cm), Weight _____ (lbs, kg), BMI _____
- ☐ Cancer, active treatment of, or in follow up, specify type of cancer_____
- ☐ Cerebrovascular disease (stroke, TIA's)
- ☐ Chronic kidney disease (estimated GFR<60)
- ☐ Chronic lung diseases limited to:
  - ☐ Interstitial lung disease
  - ☐ Pulmonary embolism
  - ☐ Pulmonary hypertension
  - ☐ Bronchopulmonary dysplasia
  - ☐ Bronchiectasis
  - ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Chronic liver diseases limited to:
  - ☐ Cirrhosis
  - ☐ Non-alcoholic fatty liver disease
  - ☐ Alcoholic liver disease
  - ☐ Autoimmune hepatitis
- ☐ Heart conditions (heart failure, coronary artery disease, or cardiomyopathies)
  - ☐ Please specify for patients with CHF if they are NYHA Class 3 or Class 4- (Class_____)
- ☐ Mental health disorders limited to:
  - ☐ Mood disorders, including depression
  - ☐ Schizophrenia spectrum disorders
- ☐ Pregnancy and recent pregnancy
  - ☐ Has an obstetrician recommended patient receive treatment? Yes_☐_ No_☐_
- ☐ On Treatment for Tuberculosis

If Group Three Criteria met, referral is complete, sign and fax as per below. Otherwise, proceed to Group Four.

Group 4 Criteria

- ☐ No history of a test confirmed COVID-19 infection in the last 6 months

AND (select one of the criteria below **<u>plus</u>** at least one risk factor**)**

- ☐ Does the Individual self-identify as indigenous* and is 40 years or older with 2 doses of 2-dose series or 1-dose of single-dose series of vaccine and more than 4 months since 2nd dose (or since single dose of 1-dose series)?**
- ☐ Individual is 50 years or older with 2 doses of 2-dose series or 1-dose of single dose series of vaccine and more than 4 months since 2nd dose (or since single dose of 1-dose series)**

** Indigenous includes people who identify as First Nations, Métis or Inuit.*

*** Individuals in the above categories who are <14 days post booster dose are candidates.*

AND have **<u>one or more of the following risk factors</u>** (please check all that apply):

- ☐ Diabetes (diet controlled, insulin, non-insulin)
- ☐ Smoking (current or previous)
- ☐ BMI >30: Height _____(inches/cm), Weight _____ (lbs, kg), BMI _____
- ☐ Cancer, active treatment of, or in follow up, specify type of cancer_____
- ☐ Cerebrovascular disease (stroke, TIA's)

- ☐ Chronic kidney disease (estimated GFR<60)
- ☐ Chronic lung diseases limited to:
  - ☐ Interstitial lung disease
  - ☐ Pulmonary embolism
  - ☐ Pulmonary hypertension
  - ☐ Bronchopulmonary dysplasia
  - ☐ Bronchiectasis
  - ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Chronic liver diseases limited to:
  - ☐ Cirrhosis
  - ☐ Non-alcoholic fatty liver disease
  - ☐ Alcoholic liver disease
  - ☐ Autoimmune hepatitis
- ☐ Heart conditions (heart failure, coronary artery disease, or cardiomyopathies)
  - ☐ Please specify for patients with CHF if they are NYHA Class 3 or Class 4- (Class_____)
- ☐ Mental health disorders limited to:
  - ☐ Mood disorders, including depression
  - ☐ Schizophrenia spectrum disorders
- ☐ Pregnancy and recent pregnancy –
  - ☐ Has an obstetrician recommended patient receive treatment? Yes_☐_ No_☐_
- ☐ On Treatment for Tuberculosis

If Group Four Criteria met, referral is complete, sign and fax as per below; if not, patient is ineligible.

Health Care Provider Information (Criteria three, four and five to be completed by a physician or nurse practitioner) Cl.A./PA's must indicate name of supervising physician

☐ Initial assessment started by Health Links Info Santé nurse as self-reported by patient. See encounter notes for details.

Name (print): _____ Designation: ☐**MD** ☐**NP** ☐**Cl.A,** ☐**PA** ☐**Other_____(specify)**

Signature: _____ Contact Number: _____

Date (D/M/Y): _____ Time: _____

Instruct patient that if they have not received a call from the clinic within 24 hours, to call Health Links-Info Santé at 204-788-8200.

Fax completed form to: Regional Coordinator - Contact health links if you don't have the number for your regional coordinator

Fax Numbers

IERHA	IERHA Clinician completes the Referral Form and **faxes** to IERHA COVID Therapies Central Intake at 1-204-482-9386.
NHR	**Fax referrals to:** The Pas Emergency Department (ED): 204-623-9207 Thompson ED: 204-778-1413 Flin Flon ED: 204-687-9640 Gillam ED: 204-652-6731 Snow Lake ED: 204-358-3570 Lynn Lake ED: 204-356-8023
PMH	**Fax all referrals to**: **Monday to Friday** Brandon Pharmacy: 204-578-4952 Dauphin Pharmacy: 204-629-3428 Neepawa Pharmacy: 204-476-2901 Russell Pharmacy: 204-773-2889 Swan River Pharmacy: 204-629-3485 **Saturday and Sunday** Brandon Pharmacy: 204-578-4952

COVID-19 IV Antiviral Outpatient & Personal Care Home Treatment Referral Form

SH-SS	**If IV Antiviral treatment option has not been determined** and the referral is coming from outside of Southern Health-Santé Sud, fax referral to (204) 379-2769 *(Note: This number is only monitored Monday – Friday)*. For phone inquiries, call (204) 379-2281. For internal referrals see contact information below. Altona Health Centre: Fax 204-324-8256 Bethesda Regional Health Centre – East Area: Fax 204-346-3767 Boundary Trails Health Centre – South Area: Fax 204-331-8874 DeSalaberry District Health Centre: Fax 204-433-7701 Notre Dame Health Centre: Fax 204-248-2768 Portage District Hospital – North Area: Fax 204-856-7028 Rock Lake Hospital: Fax 204-873-2326 Ste. Anne Health Centre: Fax 204-422-3103
WRHA	**For all outpatient referrals fax** to 204-940-1978 for centralized referral management by COVID Response Unit. For phone enquiries call 204-926-7071 **For all Long Term Care fax referral** to 204-940-8610