HOME AND COMMUNITY CARE SUPPORT SERVICES | **SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE**

PrVEKLURY® Remdesivir Infusion Referral Form

Please ensure form is completed for accuracy. Once completed fax to 1-855-352-2555.

Patient Name :	**Date of Birth:**
Primary Phone # :	**Secondary Phone # :**
Address :	**City :**
Postal Code :	**Health Card Number :**

Allergies :

Patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound?*

☐ **Yes** ☐ **No**

** If patient has a History of serious adverse or allergic reaction to the prescribed medication or related compound the patient does NOT meet the first dose in community criteria and needs to receive first dose in a surpervised hospital setting.*

Date of Medication Delivery (yyyy/mm/dd) **:**	**Time** *(24-hr clock)* **:**
Location of Medication Delivery (Name and Address) **:**	

Date of COVID-19 Symptom Onset (yyyy/mm/dd) **:**

Is patient on beta-blockers? :** ☐ Yes ☐ No

If yes, does the benefit of Remdesivir treatment outweigh the risk? : ☐ Yes ☐ No

***Patients taking beta-blockers may receive Remdesivir as a first dose in the HCCSS Nursing Clinic provided the prescriber indicates on a medical referral that the benefit of treatment outweighs the risk.*

Is this a first dose? ☐ Yes ☐ No

If no, Dose #1 date (yyyy/mm/dd) **:** _____ **; Dose #2 date** (yyyy/mm/dd) **:** _____

☐ Patient is eligible/qualifies for Remdesivir treatment as per Science Table Guidelines

☐ Recent Bloodwork attached if available (within 3 months), including LFT, AST, Cr, eGFR

☐ Current medication List attached

☐ No severe drug interactions or hepatic impairement

☐ Patient has access to a working telephone

☐ Patient/SDM understand that HCCSS Central East recommends that there is a capable adult (18 years or older) present in the home or present with the patient at the Nursing Clinic during medication administration and for 6 hours after the completion of medication administration to monitor patient for adverse reactions.

Medication Order: *Prescriber, please place your initials in the appropriate row/column to the right of the medication.*

Medication Name	Route	Dose/Instructions	Initials
Remdesivir	IV	200mg on Day 1, 100mg IV on Day 2 and Day 3	
Remdesivir	IV	100mg IV on Day 2 and Day 3	
Remdesivir	IV	100mg IV on Day 3	

For assistance completing this form call: **Bayshore Pharmacy at 1-888-313-6988.**

Prescriber Name :	**Signature :**
CPSO/CNO# :	**Primary Phone # :**
After-hours # :	**Fax # :**

Remdesivir Product Monograph: https://covid-vaccine.canada.ca/info/pdf/veklury-pm1-en.pdf

Ontario