HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

ADULT INTRAVENOUS REMDESIVIR INFUSION THERAPY ORDER FORM

Important information and instructions

- If the patient is on a beta blocker, or if they have a history of serious adverse or allergic reaction to Remdesivir or related compound, the patient must receive their first dose in a supervised hospital setting and this referral can be submitted for the second and third dose.
- Home and Community Care Support Services North East uses a 'Clinic First' approach to service delivery. **Eligibility for a home visit for IV intravenous infusion therapy will be determined by the Care Coordinator.**
- Complete all sections of the form and fax it to the applicable office location.

KIRKLAND LAKE	NORTH BAY	PARRY SOUND	SAULT STE. MARIE	SUDBURY	TIMMINS
705 567 9407	705 474 0080	1 855 773 4056	705 949 1663	705 522 3855	705 267 7795

Patient information

Surname:		First Name:
Street Address:		P.O. Box (if applicable):
City:		Postal Code:
Health Card Number:	Version Code:	Date of Birth (DD/MM/YYYY):
Phone Number(s):		

Medical Information

☐ No known drug allergies ☐ Known allergies listed below:

☐ Vascular access NOT in place prior to referral – please include orders below:

_____

☐ Vascular access in place prior to referral - Date Inserted (DD/MM/YYYY): _____

Type of Access:

☐ Peripheral Line - Needle Gauge/Size: _____	☐ Central Line Number of lumens: _____ Inserted length (cm): _____ ☐ Satisfactory position of central line/port/PICC confirmed on chest X-ray
☐ Midline	
☐ Implanted Port	

Medication Orders

Clinical Indication for Medication:

☐ Symptomatic for COVID-19 - Symptom Onset Date (DD/MM/YYYY):_____

☐ Tested Positive for COVID-19 - Date Testing Done (DD/Month/YYYY):_____

Type of Testing: ☐ Rapid Antigen Test (RAT) ☐ Polymerase Chain Reaction (PCR) Test

Treatment Orders:

☐ IV Remdesivir Standard Protocol - IV Remdesivir 200mg once on Day 1 then IV Remdesivir 100mg once daily x 2 days - Requested treatment start date (DD/MM/YYYY):_____

☐ IV Remdesivir Specific Protocol - IV Remdesivir 100mg once daily x 2 days

☐ First dose of IV Remdesivir administered – Date of dose (DD/MM/YYYY):_____

Referrer Details:

Printed Name	Signature/Designation	Date (DD/MM/YYYY)

Phone Number: _____ Fax Number: _____

Ontario