Ontario Health atHome

ADULT INTRAVENOUS REMDESIVIR INFUSION THERAPY ORDER FORM

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

Important information and instructions

- Ontario Health atHome 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.

☐ REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines. If patient does qualify, continue completing form. If first dose, complete First Dose Screener (page 2).

Patient information

Surname:		First Name:
Street Address:		P.O. Box (if applicable):
City:		Postal Code:
Health Care 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 indicate orders below:

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

Type of Access:

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

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): _____

Referral Details:

Printed Name	Signature/Designation	Date (DD/MM/YYYY)
Phone Number: _____	Fax Number: _____	

To be completed & sent along with "Referral & Treatment Form" or appropriate form

If the patient has a history of serious adverse or allergic reactions to medications listed in box #2, the patient must receive their first dose in a supervised hospital setting and this referral can be submitted for the second and third dose.

The following criteria must be completed in its entirety to ensure that patient is an appropriate candidate for receiving first dose in the community.

Patient Name: _____ DOB: _____ (dd/mm/yy)

Health Care Number: _____

	Yes	No
1. Does the patient have serious allergies, adverse reactions or anaphylactic reactions to the order medications, or related drugs?		
2. Is the medication ordered one of the following: Acyclovir, Amikacin, Amphotericin, Antineoplastics, Bisphosphonates, Colistimethate, Gentamicin, Gold, Iron, Pamidronate, Pentamidine, Tobramycin, Magnesium, Vancomycin or a special access drug/investigational? **If answer is YES to #1 and/or #2, the patient does not meet first dose criteria and needs to receive first dose in a supervised hospital setting.**		
3. Patient is 18 years of age or older:		
4. Patient has access to a working telephone?		
5. Is a hospital emergency department within a 30 minute drive from the medication administration address?		
6. Patient/SDM understands that OHaH recommends that there is a capable adult (18 years or older) present in the home or present with the patient at the SPO Nursing Clinic during medication administration and for 6 hours after the completion of medication administration to monitor patient for adverse reactions. **If answer to any of questions #4 to #6 above is NO, then patient does not qualify for first dose in the community and needs to receive first dose in a supervised hospital setting.**		
7. I have explained the risk of having the first dose in the community to the patient/SDM and the patient/SDM has given verbal consent. The signs and symptoms of anaphylactic reactions have been explained to the patient/SDM.		
8. Appropriate laboratory monitoring has been arranged for the prescribed medication if appropriate.		

Name of Prescriber: _____

Signature of Prescriber: _____

Phone Number: _____ **Date:** _____ (dd/mm/yy)