Ontario Health atHome

Infusion Therapy - IV Remdesivir Referral Form

We can only process completed referrals (signed, dated, legible). Fax completed form to 1-866-839-7299.

Name		DOB		HCN / VC	
Address				Unit	
City				Postal Code	
Phone		Alt Phone			

Preferred language for service: ☐ EN ☐ FR ☐ Other (specify):

Diagnosis	
Allergies	

Hospital Planned Discharge Date		**Infection Control Precautions are:** DROPLET, AIRBORNE and CONTACT

☐ **Use alternate contact (instead of patient) for assessment, due to**

☐ Preference ☐ Hearing ☐ Cognition ☐ Language ☐ Other (specify):

Alt Contact Name		Relationship to pt		Phone	

If any answers to the questions below are "No", we are unable to administer the first dose of IV Remdesivir in the community.	Yes	No
Has the prescriber confirmed the patient does not have any serious allergies / adverse reactions to the ordered medication or related drugs?	☐	☐
Is the patient at least 18 years old?	☐	☐
For six hours after receiving the first dose in our nursing clinic and should an adverse reaction occur, does the patient have access to a working telephone to call EMS?	☐	☐
To monitor the patient for adverse reactions for six hours after the medication is administered, the patient / SDM understands that we recommend a capable adult (18 years or older) be present in the home or with the patient.	☐	☐

Remdesivir

1) ☐ Patient qualifies for treatment, per Ontario Health guidelines

2) Date of COVID-19 symptom onset: Date of positive test:

3) ☐ Remdesivir 200 Mg IV on Day 1, 100mg IV daily on days 2 and 3. All doses via peripheral IV or other vascular access device.

4) Is Patient on beta-blockers? ☐ Yes ☐ No.

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

5) Is this a first dose? ☐ Yes ☐ No.

If no, Dose 1 date & time: Dose 2 date & time:

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☐ I have confirmed that the patient does not have any serious allergies or adverse reactions tothe ordered or related medications. ☐ I have confirmed there are no contraindications to patient receiving IV Remdesivir in the community, including review of recent bloodwork (Cr, ALT, AST & eGFR within three months), hepatic and renal function, pregnancy/breastfeeding status. ☐ I have explained the risks of having the first dose in the community to the patient / most responsible person and the patient / most responsible person has given verbal consent.			
Additional Information/Orders			
Physician/NP Name (please print)			
Signature		**Date**	
If delegate, name of most responsible provider (MRP)			
MRP phone/pager number for follow-up or urgent situations(including after hours)			