EISENHOWER HEALTH

39000 Bob Hope Drive,
Rancho Mirage, CA 92270
760.834-3516 – Direct
760.773.4209 – Fax
www.emc.org/covidinfusion
Days: Monday/Wednesday/Friday

Monoclonal Antibody Infusion Mild-Moderate COVID-19 or Post-Exposure Prophylaxis

1. PATIENT INFORMATION

Name: _____ Birth Date: _____ Age:_____

Height: _____ Weight: _____ BMI: _____ Gender: ( ) Male ( ) Female

SS#: _____ Preferred Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Known allergies: _____

2. PROVIDER INFORMATION/PATIENT ELIGIBILTY

Provider Name: _____

Phone: _____ Fax: _____

Key Contact for Provider _____ Phone #: _____

COMPLETE THE FOLLOWING **Date symptoms started:** _____

Vaccination Status: ( )Unvaccinated ( )Vaccinated ( )Vaccinated + Booster

COVID-19 Test Result: ( ) Pos ( ) Neg Date of test: _____ Exposure Date:_____

Clinical Risk Factors –select all that apply:

( ) Immunosuppressive Disease or Treatment-specify: _____

( ) Chronic Lung Disease (COPD, Interstitial lung disease, moderate-severe asthma):_____

( ) Cardiovascular Disease: ☐CHF ☐CAD ☐congenital heart disease ☐atherosclerosis **( )** Hypertension

( ) Chronic Kidney Disease (GFR <60) GFR: _____ **( )** Diabetes **( )** Chronic Liver Disease

( ) Body Mass Index (obese/overweight) **( )** Cerebrovascular Disease **( )** Sickle Cell Disease

( ) Neurodevelopmental disorder (cerebral palsy, congenital anomalies) or Medical-related technology (trach, gastrostomy)

( ) Mood disorders, including depression, schizophrenia spectrum **( )** Smoker: ☐current ☐former

( ) Neurodevelopmental disorder (cerebral palsy, congenital anomalies) or Medical-related technology (trach, gastrostomy)

Patient Eligibility for Monoclonal Antibodies

Patients meeting any of the following criteria are NOT ELIGIBLE for treatment:

a. Hospitalized due to COVID-19
b. Require oxygen therapy due to COVID-19 or require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity
c. O2 saturation < 92%
d. Treatment with other FDA-authorized agents for COVID-19, such as Paxlovid, molnupiravir, remdesivir, REGEN-COV, etc.

3. PROVIDER SIGNATURE - Provider, please sign and date below. Please attach all patient-related documents.

I, the referring provider, am the patient's PCP or other continuity provider and attest to the facts provided above. I have arranged for the patient to follow up with me/my designee following Antibody infusion.

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. The patient's clinical status will be re-evaluated at the COVID infusion center at the appointment time. If the patient is deemed in need of hospital care, s/he will be referred immediately.

Signature Indicates Provider Agreement: _____ Date: _____

FAX REFERRAL, MOST RECENT OFFICE NOTE, MEDICATIONS, ALLERGIES & RELEVANT TEST RESULTS TO 760-773-4209