Infusion Therapy - IV Remdesivir Referral Form

- Patients will receive treatment in our community nursing clinics, unless under exceptional circumstances.
- We process only completed referrals (legible, signed, dated). Fax to 613.745.6984 or 1.855.450.8569.

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

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

Diagnosis	
Allergies	

If applicable, 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?	☐	☐
Has the prescriber confirmed the patient has not experienced anaphylaxis to Remdesivir or anaphylaxis of unknown origin?	☐	☐
Is the patient at least 18 years old?	☐	☐
For six hours after receiving the first dose and should an adverse reaction occur, does the patient have access to a working telephone to call 911 or to a hospital within approximately 30 minutes drive from medication administration address?	☐	☐
To monitor the patient for adverse reactions for six hours after the medication is administered, the patient / SDM understands that a capable adult (18 years or older) should be present in the home or with the patient.	☐	☐

Treatment		
	1) ☐ Patient qualifies for Remdesivir, per Ontario COVID-19 Science Advisory Table Guidelines	
	2) Date of COVID-19 symptom onset	Date of positive test
	3) ☐ Remdesivir 200 mg IV on Day 1, 100 mg IV daily on days 2 and 3. All doses via peripheral IV.	
	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

☐ I have confirmed that the patient does not have any serious allergies or adverse reactions to the 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 number** for urgent situations	

Confidential when completed. If you received this form in error, please call us at 1.800.538.0520.