

**PrVEKLURY® Remdesivir Infusion Referral Form**

Please ensure form is completed for accuracy. Once completed fax to 1-855-352-2555.

<b>Patient Name :</b>		<b>Date of Birth:</b>
<b>Address :</b>		<b>City :</b>
<b>Postal Code :</b>	<b>Health Card Number :</b>	
<b>Allergies :</b> Patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound?*		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
* If patient has a History of serious adverse or allergic reaction to the prescribed medication or related compound the patient does <u>NOT</u> meet the first dose in community criteria and needs to receive first dose in a supervised hospital setting.		

<b>Date of Medication Delivery (yyyy/mm/dd) :</b>	<b>Time (24-hr clock) :</b>
<b>Location of Medication Delivery (Name and Address) :</b>	

<b>Date of COVID-19 Symptom Onset (yyyy/mm/dd) :</b>
<b>Is patient on beta-blockers?*** :</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, does the benefit of Remdesivir treatment outweigh the risk? :</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
***Patients taking beta-blockers may receive Remdesivir as a first dose in the HCCSS Nursing Clinic provided the prescriber indicates on a medical referral that the benefit of treatment outweighs the risk.
<b>Is this a first dose?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If no, Dose #1 date (yyyy/mm/dd) :</b> _____ ; <b>Dose #2 date (yyyy/mm/dd) :</b> _____
<input type="checkbox"/> Patient is eligible/qualifies for Remdesivir treatment as per <a href="#">Science Table Guidelines</a> <input type="checkbox"/> Recent Bloodwork attached if available (within 3 months), including LFT, AST, Cr, eGFR <input type="checkbox"/> Current medication List attached <input type="checkbox"/> No severe drug interactions or hepatic impairment <input type="checkbox"/> Patient has access to a working telephone <input type="checkbox"/> Patient/SDM understand that HCCSS Central East recommends that there is a capable adult (18 years or older) present in the home or present with the patient at the Nursing Clinic during medication administration and for 6 hours after the completion of medication administration to monitor patient for adverse reactions.

**Medication Order:** Prescriber, please place your initials in the appropriate row/column to the right of the medication.

Medication Name	Route	Dose/Instructions	Initials
Remdesivir	IV	200mg on Day 1, 100mg IV on Day 2 and Day 3	
Remdesivir	IV	100mg IV on Day 2 and Day 3	
Remdesivir	IV	100mg IV on Day 3	

For assistance completing this form call: **Bayshore Pharmacy at 1-888-313-6988.**

<b>Prescriber Name :</b>	<b>Signature :</b>
<b>CPSO/CNO# :</b>	<b>Primary Phone # :</b>
<b>After-hours # :</b>	<b>Fax # :</b>

Remdesivir Product Monograph: <https://covid-vaccine.canada.ca/info/pdf/veklury-pm1-en.pdf>