

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 <input type="checkbox"/> FR <input type="checkbox"/> Other <input type="checkbox"/> (specify)					
Diagnosis					
Allergies					
If applicable, Hospital Planned Discharge Date		Infection Control Precautions are DROPLET, AIRBORNE and CONTACT			
<input type="checkbox"/> Use alternate contact (instead of patient) for assessment, due to <input type="checkbox"/> Preference <input type="checkbox"/> Hearing <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> 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 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) <input type="checkbox"/> Patient qualifies for Remdesivir, per Ontario COVID-19 Science Advisory Table Guidelines				
	2) Date of COVID-19 symptom onset			Date of positive test	
	3) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, does the benefit of treatment outweigh risk? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	5) Is this a first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No. If no, Dose 1 date & time _____ Dose 2 date & time _____				
<input type="checkbox"/> I have confirmed that the patient does not have any serious allergies or adverse reactions to the ordered or related medications.					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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.