COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral

Regional Sites (Please select one, walk-in not accepted):

* Health Sciences North – COVID Assessment Centre, 2050 Regent St, Sudbury, Fax: 705-523-4464
* Humber River Hospital – Finch RCC, COVID Assessment Centre, 2111 Finch Ave W, North York, Email: [CACfinch@hrh.ca](mailto:CACfinch@hrh.ca)
* The Ottawa Hospital – Civic Campus, 1052 Carling Ave, Ottawa, Fax: 613-739-6751
* Scarborough Health Network – Centenary Hospital, 2867 Ellesmere Rd, Scarborough, Fax: 416-281-7384
* St. Joseph’s Healthcare Hamilton – ED Entrance, 50 Charlton Ave East, Hamilton, Fax: 905-522-4469
* Thunder Bay Regional Health Sciences Centre – 984 Oliver Rd, Suite 101, Thunder Bay, Fax: 807-623-6631, Tele: 807-935-8101
* Windsor Regional Hospital – 1030 Ouellette Ave, Windsor, Email: [WRHmAbclinic@wrh.on.ca](mailto:WRHmAbclinic@wrh.on.ca)

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| **Patient Information** | |
| **Name: Date of birth: Allergies:**  **Address: City/Prov: /**  **Postal: Phone: HCN:** | |
| **NOTE: For patients with mild COVID-19 with confirmed COVID-19.** These products are available for use under an interim authorization (Interim Order) by Health Canada to prevent progression of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) who are at high risk for progression to severe COVID-19, including hospitalization or death.  In order to qualify for therapy, patients need to a) Be symptomatic b) Be within 7 days of symptom onset c) Meet 1 criteria under vaccinated or unvaccinated d) Be willing to travel to the clinic to receive therapy e) Expected survival > 1 year from all causes | |
| **Criteria for Use** (all fields must be completed to be eligible for treatment) | |
| * **Date of symptom onset:** Treatment must be given within 7 days of symptom onset. * **Symptoms:** * **Date of positive COVID-19 test:** * **Does this person have a history of prior COVID-19 within the past 90 days?** * **Has this person received at least two doses of vaccine?**   Yes (2 or more doses) – do they meet any of the following criteria?  Hematologic Malignancy or Bone Marrow Transplant (Please specify: )  Solid Organ Transplant (Please specify: )  Significant immunosuppression (Please indicate type: high-dose corticosteroids > 2 weeks, alkylating agents, antimetabolites, cancer chemotherapy, TNF inhibitors, anti-CD20 agents and other immunosuppressive biologic agents)  Primary immunodeficiency (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Advanced or untreated HIV  No (0 or 1 doses) – do they meet any of the following criteria?   * Age >= 60 * Age >= 50 AND at least one of the following: * Indigenous (First Nations, Inuit, or Métis)   Obesity (BMI >= 30)  Diabetes Mellitus  Chronic Kidney Disease (GFR < 15 or dialysis)  Immunosuppressed as above (Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Sickle Cell Disease  Intellectual disability  Cerebral Palsy  Other severe risk factor (Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| **Referral Attestation** (Must be checked to be eligible for treatment) | |
| * I affirm that my patient meets above criteria for use |  |
| Clinician Name (print): Direct Contact Number (not office line): Clinician Signature: Date/Time: / College #: | |