Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

COVID-19 MONOCLONAL ANTIBODY THERAPY REFERRAL
Treatment of Symptomatic COVID-19

PATIENT'S NAME ____________________

MED. REC. # ____________________

DOB ____________________

Patient Identification

MR3405

Patient's Name: ______________________________ **DOB:** ____ / ____ / ____

Preferred Language for Healthcare Discussions: ______________________________

Preferred Phone Number: ______ - ______ - ________

Beth Israel Medical Center Medical Record Number (*if available*): ______________________________

A medical record number (MRN) at Beth Israel Deaconess Medical Center is required to process this referral. If MRN is not available, please instruct patient to contact Patient Registration at **617-754-8240 as soon as possible.*

COVID-19 SYMPTOM ONSET AND DIAGNOSIS

Date of Symptom Onset (must be within 7 days of this referral): ____ / ____ / ____

Date of Positive COVID-19 PCR or Antigen test: ____ / ____ / ____

VERIFICATION OF ADDITIONAL REQUIREMENTS FOR REFERRAL

- ☐ Check here to verify that patient has at least one contraindication to treatment with Nirmatrelvir / Ritonavir (Paxlovid™). *Select all that apply*:
  - ☐ Drug-drug interactions listed as an absolute contraindication
  - ☐ Symptom onset greater than 5 days
  - ☐ Other medical contraindications (severe liver disease, GFR less than 30 mL/min, uncontrolled HIV infection)
- ☐ Check here to verify that patient has **at least one risk factor** for progression to severe COVID-19 (https://covid-19.bilh.org/wp-content/uploads/bilh-severe-covid-19-risk-factors.pdf)
- ☐ Check here to verify that patient **does not require oxygen** therapy due to COVID-19 (including an increase in baseline oxygen flow in patients on chronic oxygen therapy)
- ☐ Check here to verify that patient **weighs more than 40 kg** (88 lb)

REFERRING PROVIDER INFORMATION

Name: ______________________________ **Institution:** ______________________________

Office Number: ______ - ______ - ________ Extension, if applicable: __________

Provider Secure Email: ______________________________

Note: *All communication about your referral will be sent to this email address. Provide only one email address and verify it is correct and legible.*

ORDERING PROVIDER AUTHENTIFICATION:

X______________________________ ______________________________ ____/____/____ __ __ __ __

Circle: M.D. / N.P. / P.A. - Signature | Print Name | Date | Time (24 hr)

MR 3405 OP (Rev. 09/22)

Submit completed referral via secure email to: covidmab@bidmc.harvard.edu or **fax to:** 617-754-8861