Yale NewHaven Health

Referral Requisition Form for COVID-19 Monoclonal Antibody Therapy

Please fax to: 475-246-9923

Referring Clinician Information

Clinician name___________________________ Clinician phone number____________________

Patient Information

Last name_______________________ First name___________________________

Address_____________________________City____________________State____________Zip_________

Date of birth__________________Phone number_________________MR (if available) _________________

Date of COVID-19 Positive test result____________________ Date of symptom onset___________________

In order for the patient to be eligible for bamlanivimab/etesevimab or casirivimab/imedevimab patients have to meet one of the following criteria. Please select which of the following criteria the patient meets:

- ☐ Patient is ≥ 65 years of age

Patients ≥ 55 years of age AND the following comorbidity:

- ☐ Chronic obstructive pulmonary disease/other chronic respiratory disease

Patients with ANY of the following co-morbidities:

- ☐ BMI ≥ 35 kg/m^2
- ☐ Chronic Kidney Disease
- ☐ Congestive Heart Failure
- ☐ Cirrhosis
- ☐ Diabetes mellitus
- ☐ Parkinson's disease
- ☐ Sickle cell disease
- ☐ Severe pulmonary disease defined as one of the following: COPD with continuous home oxygen, pulmonary hypertension or pulmonary fibrosis, cystic fibrosis
- ☐ Immunosuppressed status due to an underlying immunocompromising condition or use of immunosuppressive therapy (list condition or immunosuppressive therapy here: __________________)

Patient aged 12-17 with one of the following:

- ☐ Congenital or acquired heart disease
- ☐ Neurodevelopmental disorders
- ☐ Medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
- ☐ Chronic respiratory disease excluding asthma

Please also confirm you have completed the following (these must be checked off prior to submitting referral):

- ☐ Verified that patient meets criteria for infusion at this time as indicated on the information above (patient can only be offered infusion for criteria outlined at this time)
- ☐ Reviewed the information below and obtained verbal informed consent for the infusion
- ☐ Informed the patient to expect a phone call from a Yale number with scheduling information
- ☐ I provided the patient with the YNHHS Patient Information Sheet for bamlanivimab and casirivimab/imdevimab

Provider signature ____ Date of referral ___________

3/23/2021