COVID-19 Assessment Centre Referral Form
(For Paxlovid Therapy Assessment)

☐ **Scarborough Health Network (Birchmount site)**	**3030 Birchmount Road** **Hours of operation:** **8 am – 6:30 pm (7 days a week)**	☐ **Email referral form to:** **covidassessmentcentre@shn.ca**
☐ **Scarborough Health Network (Centenary site)**	**2867 Ellesmere Rd** **Hours of operation:** **Monday, 8 a.m. – 4 p.m.** **Friday, 11 a.m. – 7 p.m**	

NOTICE: Referrals to the SHN COVID-19 Assessment Clinic for Paxlovid therapy for COVID-19 patients with symptom onset 5 days or greater OR for long COVID-19 shall be respectfully declined due to patient ineligibility for Paxlovid therapy.

Patient Information

Name: _____ Sex:_____ Date of Birth (DD/MM/YY): _____

Address:_____

Postal Code:_____ Phone Number: _____ HCN:_____

Height (cm):_____

Weight (kg):_____

Allergies:
☐ No known drug allergies

*** REFERRING PHYSICIAN/REFEREE: PLEASE ATTACH A COPY OF THE PATIENT'S CURRENT MEDICATION LIST (prescription, non-prescription, over the counter and herbal medications WITH THE COMPLETED REFERRAL FORM) IF AVAILABLE ***

Brief medical history and relevant clinical concerns *(where applicable, documentation can be attached):*
☐ I confirm this information is provided in attached documentation (if not provided below)

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 patients weighting at least 40 kg who are at high risk for progression to severe COVID-19, including hospitalization or death.
Paxlovid is indicated for patients 18 years and older.

CRITERIA FOR PAXLOVID THERAPY

Patients must meet Criteria 1, 2, 3, and 4 and ALL fields must be completed to be eligible for Paxlovid treatment [nirmaltravir plus ritonavir]

1	☐ **Patient is 18 years and older** (Paxlovid is indicated for patients 18 years and older.)
2	☐ **Patient is within 5 days of symptom onset** (Treatment must be given within 5 days of symptom onset for Paxlovid) ☐ **Date of symptom onset:** _____
3	☐ **Patient has an active COVID-19 infection** ☐ **Date of positive COVID-19 test:** _____ **AND** ☐ **Type of COVID-19 test used** ☐ Rapid Antigen Test ☐ PCR ☐ Rapid Point of Care Molecular Test [ID Now]
4	**Patient must meet at least one criteria under A, B, C or D below:** ☐ A) **Immunocompromised or immunosuppressed individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection (regardless of vaccine status) defined as one of the following:** ☐ Active treatment for solid tumor and hematologic malignancies (including individuals with lymphoid malignancies who are being monitored without active treatment) *(Specify:* _____*)* ☐ Receipt of solid-organ transplant and taking immunosuppressive therapy *(Specify:* _____*)* ☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)

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☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome, common variable immunodeficiency, Good's syndrome, hyper IgE syndrome) *(Specify: _____)*

☐ Advanced or untreated HIV infection

☐ Active treatment with high-dose corticosteroids (i.e. equal or greater than 20 mg prednisone or equivalent per day when administered for equal or greater than 2 weeks)

☐ Active treatment with alkylating agents, antimetabolites (including methotrexate), transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis factor (TNF) blockers or other biologic agents that are immunosuppressive or immunomodulatory *(Specify: _____)*

☐ B) **Age 70 years and older** (irrespective of COVID-19 vaccination status)

☐ C) **Age 60 years and older with <u>less than</u> 3 doses of a COVID-19 vaccine**

☐ D) **Age 18 years and older with <u>less than</u> 3 doses of a COVID-19 vaccine AND at least 1 of the following risk factors:**

- Diabetes Mellitus
- Obesity (Body mass index equal or greater than 30 kg/m^2)
- Cardiovascular Disease (e.g. heart disease, congestive heart failure, hypertension)
- Chronic Kidney Disease (eGFR 30 to less than 60 mL/min/1.73 m^2)
- Chronic Liver Disease (Child-Pugh class B)
- Chronic Respiratory Disease (including cystic fibrosis)
- Cerebral Palsy
- Intellectual or Developmental Disability
- Sickle Cell Disease
- Pregnancy

Prescriber/Referee Attestation (Must be checked to be eligible for treatment)

☐ I affirm that my patient meets above criteria for use

Prescriber/Referee Name (print): _____ Direct Contact Number (not office line): _____

Prescriber/Referee Signature: _____ Date/Time: _____

CPSO# (if applicable): _____

Referral Physician's Billing # (if applicable): _____

☐ RN/RPN (if applicable)