Last updated: April 20, 2022

Referral to Connected COVID Care Program

EMAIL COMPLETED FORM TO: COVIDCare@uhn.ca or fax 416-340-4135

Instructions for completion

1. Please complete the form where possible and submit to: COVIDCare@uhn.ca or fax 416-340-4135
2. The referred patient will receive a virtual assessment from a clinician. Wherever possible we aim for within 24 hours. Patients who are eligible for therapeutics will be prioritized

IMPORTANT: If you have already assessed your patient and would like to prescribe therapeutics directly (without virtual assessment from the clinic), please complete one of the following forms instead:

- UHN Oral Paxlovid Referral Form & Prescription Form (virtual pharmacy support is available for consultation and every referral form will be reviewed by a pharmacist)
- Remdesivir Referral Form

Patient Demographics – please enter all relevant patient data		
Patient Full Name:		
Date of Birth:	**HCN** (with version code):	
Patient Phone:	**Email:**	
Patient Address:		**Postal Code:**
Referring Clinician		
Referring Clinician:		
Clinician Phone:	**Email:**	
Virtual Care Clinic Assessment		
Does the patient consent to being contacted by a scheduler for a virtual care visit?	☐ Yes ☐ No	
History		
Date of Symptom Onset:	**Date of Positive Test:**	
Test Type:	☐ PCR Test ☐ Rapid Antigen Test (administered at-home) ☐ Rapid Antigen Test (administered by health care provider)	
Allergies:		**OR ☐ No known allergies**
Any Ongoing Symptoms?		
Any additional information (e.g. clinical or psychosocial concerns, major comorbidities or pending investigations)		

COVID-19 Therapeutics

Only complete the following section if: patient is eligible for therapeutics. Patient will be assessed virtually, and if eligible, the clinic clinician will act as prescriber. The eligibility criteria is included in the section.

Please provide as much information in the section below as available to support the assessment.

Criteria for Use	
Patient must symptomatic and within 5-7 days	
Please select the eligibility criteria the patient meets:	

☐ **Immunocompromised individuals of any age or vaccination status (please specify):**
☐ Active Hematologic malignancy or post cell therapy (allogeneic/autologous bone marrow transplant, CAR-T cell therapy in last 6 months)
☐ Solid Organ Transplant (Organ:_________________)
☐ Significant immunosuppression (Please indicate type):
  ☐ High-dose corticosteroids > 2 weeks
  ☐ Alkylating agents
  ☐ Antimetabolites
  ☐ Myelosuppressive anti- cancer chemotherapy
  ☐ TNF inhibitors
  ☐ Anti-CD20 agents and other immunosuppressive biologic agents including for GVHD)
☐ Primary immunodeficiency
☐ Advanced or untreated HIV
	☐ **High risk of hospitalization based on age, number of COVID-19 vaccine doses and risk factors (please specify):**
	☐ Age ≥ 70
	☐ Age ≥60 and received <3 doses
	☐ Age ≥18, received <3 doses and at least one of the following risk conditions:
	  ☐ Obesity (BMI >/= 30 kg/m^2)
	  ☐ Diabetes
	  ☐ Heart disease, hypertension, congestive heart failure
	  ☐ Chronic respiratory disease, including cystic fibrosis
	  ☐ Cerebral palsy
	  ☐ Intellectual and developmental disabilities
	  ☐ Sickle cell disease
	  ☐ Moderate or severe kidney disease (eGFR <60 mL/min)
	  ☐ Moderate or severe liver disease
	  ☐ Pregnant and unvaccinated (zero doses)

Please list ALL Current Medications (List in form or attach a list or screen shot):	
Prescription Medications (Drug Name, Dose and Frequency):	Herbals:

Renal Function	**eGFR:**	**Date:**	☐ **Not Available**
	If eGFR < 30 ml/min PAXLOVID or Remdesivir should not be used (Remdesivir may be considered if approved by ID physician)		
Liver Tests (e.g. ALT, ALP, Bili, INR)		☐ **Not available**	