Last updated: December 19, 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 WCH Paxlovid Referral Form & Prescription
- 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 ≥ 18 years old**

☐ Active Hematologic malignancy or post cell therapy (allogeneic/autologous bone marrow transplant, CAR-T cell therapy in last 6 months)

☐ Solid Organ or blood stem cell Transplant (___________________________)

☐ 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 risk factors or inadequate immunity)**

☐ Age ≥60

☐ Age 18–59 who have one or more comorbidity that puts them at higher risk of severe COVID-19 disease:

- ☐ Cerebrovascular disease
- ☐ Chronic kidney disease (eGFR <60 mL/min)
- ☐ Chronic liver disease (limited to: cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, and autoimmune hepatitis)
- ☐ Chronic lung diseases (limited to: bronchiectasis, chronic obstructive pulmonary disease, interstitial lung disease, pulmonary hypertension, pulmonary embolism)
- ☐ Cystic fibrosis
- ☐ Diabetes mellitus, type 1 and type 2
- ☐ Disabilities (e.g. Down syndrome, learning, intellectual, or developmental disabilities; ADHD; cerebral palsy; congenital disabilities; spinal cord injuries)
- ☐ Heart conditions (e.g., cardiomyopathies, coronary artery disease, heart failure, etc.)
- ☐ Mental health disorders (limited to: mood disorders, including depression; schizophrenia spectrum disorders)
- ☐ Obesity (BMI >/= 30 kg/m^2)
- ☐ Pregnancy and recent pregnancy
- ☐ Smoking, current or former
- ☐ Tuberculosis

☐ Age 18–59 with inadequate immunity, i.e.:

- ☐ Unvaccinated or incomplete primary series
- ☐ Completed primary series AND last COVID-19 vaccine dose was 6+ months ago AND last SARS-CoV-2 infection was 6+ months ago

☐ Patient does not meet above eligibility criteria, but treatment determined appropriate (please provide reasoning):

Please list ALL Current Medications (List in form or attach a list or screen shot):

Prescription Medications (Drug Name, Dose and Frequency):	Herbals:

Renal & Liver Impairment

- If eGFR < 30 ml/min, PAXLOVID can be used, a dose adjustment is required. If eGFR >30 to <60mL/min, dose adjustment is required for moderate renal impairment. An eGFR within the last 3 months is recommended. If an eGFR is not available, please assess patient for risk factors associated with reduced kidney function (diabetes, recent surgery, hypertension, etc.)
- If receiving dialysis treatment - on days of treatment, PAXLOVID is to be administered *after* treatment. Please refer to *Nirmatrelvir/Ritonavir (Paxlovid) and Remdesivir Use in Patients on Dialysis with COVID-19*
- PAXLOVID is NOT recommended in severe hepatic impairment (Child-Pugh Class C)

Renal Function	**eGFR:**	**Date:**	☐ **Not Available**
Liver Tests (e.g. ALT, ALP, Bili, INR)		☐ **Not available**	