Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

COVID-19 AMBULATORY TREATMENT REFERRAL

Treatment of Symptomatic COVID-19

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™). *Check 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 **all of the following** conditions are met:

- **Does not require oxygen** therapy due to COVID-19 (including an increase in baseline oxygen flow in patients on chronic oxygen therapy)
- Is not known to have liver enzyme derangements with AST / ALT equal to or greater than 5 x ULN

RISK FACTORS FOR SEVERE INFECTION TO ASSIST WITH PRIORITIZATION, IF REQUIRED

Check all that apply:

☐ Severe immunosuppression according to BILH COVID-19 Vaccination & Therapeutics – Categorization of Immunosuppression (https://covid-19.bilh.org/wp-content/uploads/bilh-covid-19-immunosuppression-categories.pdf)

☐ Moderate immunosuppression per BILH guidance as above

☐ Does not have moderate or severe immunosuppression but HAS A HIGH-RISK UNDERLYING condition as defined by the CDC (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html)

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COVID-19 VACCINATION STATUS

Primary Series:
2 doses of original monovalent **or**
1 dose of bivalent mRNA vaccine **or**
2 doses of Novavax **or**
1 dose of Johnson & Johnson vaccine

☐ Unvaccinated = Has never completed a COVID-19 primary vaccine series

☐ Vaccinated = Has completed a COVID-19 primary vaccine series at any time

Booster Status:

☐ HAS received ANY booster dose

☐ Has NOT received ANY booster dose

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)

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