Ontario

Home and Community Care Support Services North West
961 Alloy Drive
Thunder Bay, ON P7B 5Z8

Services de soutien à domicile et en milieu communautaire Nord-Ouest
961, promenade, Alloy
Thunder Bay, ON P7B 5Z8

Surname: _____ First Name: _____
Street Address: _____ City: _____
Postal Code: _____ Phone #: _____
HCN & VC: _____ DOB: _____

REFERRAL TO HOME AND COMMUNITY CARE SUPPORT SERVICES FOR ADULT INTRAVENOUS REMDESIVIR

Complete all sections of this form and fax to 807-346-4625

IMPORTANT INFORMATION AND INSTRUCTIONS	Yes	No
Questions 1-8 MUST be answered 'Yes' and questions 9-10 MUST be answered 'No' in order for this referral to be processed.		
1. Patient is 18 years of age or older.	☐	☐
2. Patient has a capable individual (18+ years of age) available to monitor/stay with them for the first 6 hours post medication administration to watch for adverse reactions.	☐	☐
3. Patient has a working telephone.	☐	☐
4. Patient is eligible/qualifies for Remdesivir treatment as per Science Table Guidelines.	☐	☐
5. For **first dose** administration, the patient must live within 30 minutes of a hospital emergency department.	☐	☐
6. Patient's current medication list is attached.	☐	☐
7. Patient's most recent (within 3 months) Bloodwork is attached, including LFT, AST, Cr, eGFR.	☐	☐
8. Referring MD/NP has explained to patient/most responsible person the risk of having the **first dose** in the community and the patient/most responsible person has given verbal consent. The signs and symptoms of anaphylactic reaction have been explained to the patient/most responsible person.	☐	☐
9. Patient has a history of anaphylaxis, anaphylaxis of unknown origin or other medication allergies.	☐	☐
10. Patient has serious allergies, adverse reactions or anaphylactic reactions to the ordered medication, or related drug.	☐	☐
11. Patient is taking oral beta blockers. **Beta blockers can decrease response to anaphylaxis protocol, ie: Epinephrine.** If the patient is on a beta blocker, or if they have a history of serious adverse or allergic reaction to Remdesivir or related compound, the patient **must** receive their first dose in a supervised hospital setting and this referral can be submitted for the second and third dose).	☐	☐

MEDICAL INFORMATION

☐ Vascular Access NOT in place prior to referral – please include orders here: Click or tap here to enter text.

☐ Vascular access in place prior to referral – Date Inserted: Click or tap to enter a date.
Type of Access:
- ☐ Peripheral Line – Needle Gauge/Size: Click or tap here to enter text.
- ☐ Midline
- ☐ Implanted Port
- ☐ Central Line - Number of Lumens: Click or tap here to enter text. Inserted Length (cm): Click or tap here to enter text.

☐ Satisfactory position of central line/port/PICC confirmed on chest x-ray.

CLINICAL INDICATION FOR MEDICATION

☐ Symptomatic for COVID-19. Symptom onset date: Click or tap to enter a date.
☐ Tested positive for COVID-19. Date testing done: Click or tap to enter a date.
Type of Testing: ☐ Rapid Antigen Test (RAT) ☐ Polymerase Chain Reaction (PCR) Test

MEDICATION ORDERS

Medication	Route	Dose/Instructions	Initials
Remdesivir	IV	☐ 3 day dose: 200mg on Day 1, 100mg on Days 2 & 3	
Remdesivir	IV	☐ 2 day dose: 100 mg on Days 2 & 3 - First dose administered on: Click or tap to enter a date.	
Remdesivir	IV	☐ 1 day dose: 100mg on Day 3 - First dose administered on: Click or tap to enter a date.	

REFERRER DETAILS

Printed Name: Click or tap here to enter text. Signature/Designation: Click or tap here to enter text.

Phone #: Click or tap here to enter text. Fax #: Click or tap here to enter text. Date: Click or tap to enter a date.