The Hospitals of PROVIDENCE
MEMORIAL CAMPUS

MONOCLONAL ANTIBODY INFUSION
PATIENT SCREENING FORM ADULT and PEDIATRIC

Patient Name: ____ **Todays Date:** ______/______/_____

D.O.B.: ______/_______/__________ **Cell Phone:** ___________________________

Onset of mild to moderate COVID-19 symptoms: __________/______/_______

Weight: _____

Height: _____

Allergies:
____
____
____

Symptoms less than 10 days? ☐ YES ☐ **NO** STOP **NOT ELIGIBLE**

SpO2________% > 90% ☐ YES ☐ **NO** STOP **NOT ELIGIBLE**
With no new or increase O[2]

Stable for discharge home: ☐ *YES* ☐**NO** STOP **NOT ELIGIBLE**

Treatment should be considered for high-risk individuals.

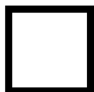
□ **Tier 1** – Patient is Immunocompromised (vaccinated or unvaccinated) OR Age $\geq$ 75 years and unvaccinated; OR Age ≥ 65 with additional clinical risk factors OR Pregnant with a positive Covid result
□ **Tier 2** – Unvaccinated individuals at risk of severe disease not included in Tier 1 (anyone aged ≥ 65 or anyone aged <65 years with clinical risk factors)
□ **Tier 3** – Vaccinated individuals at high risk of severe disease (anyone aged ≥75 years or anyone aged ≥65 with clinical risk factors)
□ **Tier 4** – Vaccinated individuals at risk of severe disease (anyone aged ≥65 or anyone aged <65 with clinical risk factors)

- *Vaccination is defined as all doses + booster doses*
- *Clinical Risk Factors: Immunosuppressed or currently receiving immunosuppressive treatment, Chronic Kidney Disease, Chronic Liver Disease, Chronic Lung Disease, BMI $\geq$ 25, Cancer, Diabetes, Heart Disease, Hypertension, Neurodevelopmental Disorder, Pregnancy, Sickle Cell Disease, Medical Devices (Trach, Gastrostomy Tube, etc.)*

Date of COVID test: _______/_______/_______ **COVID test result positive** □ YES □ NO

Positive Test Type: □ PCR □ Antigen

Appointment will be made by medication availability (must be within 10 days of symptoms onset)



Sotrovimab 500 mg intravenous (IV) infusion*

30 Minute Infusion + 1 hour of observation for signs and symptoms of anaphylaxis-type reactions

Physician/APP: ____________________________________ ____

PRINT NAME SIGNATURE

Provider Phone: _____________________________

Fax a copy of this completed form, patient ID, & a copy of the positive COVID test to 915- 577- 6192
Provide patient with instructions and copy of screening form and map with directions to infusion center
REV. 1/7/22