Monoclonal Antibody Patient Information Sheet

Patient name:

Contact phone: alternative:

Provider name:

Contact phone:

Back-up:

Age:

Ht: (For order, not intake)

Wt: (For order, not intake)

BMI:

Vaccination Status:

Symptom Onset:

Symptom Description: (for order not intake)

Positive Test date sampled:

**NOTE: PAXLOVID IS FIRST LINE PER NIH TREATMENT GUIDELINES 4/8/22**

**IS PATIENT A CANDIDATE FOR PAXLOVID: Y or N. If no, why not\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medical Conditions:

Immunosuppression (describe):

 COPD/ Chronic Lung Disease:

Oxygen: (Y/N): If “Y”: baseline:

Medical device (trach, PEG, etc)

DM:

Pregnancy:

Htn: Cardio-vasc:

CKD:

Developmental disability:

Race:

Other Chronic Diseases: