BAPTIST HEALTH MEDICAL CENTER-LITTLE ROCK INFUSION CLINIC

Monoclonal Antibody Provider Referral Form

Patient Name: _____

DOB(Age): _____ (_____) Patient Contact Number:_____

Physician or Clinic Name:_____

Physician Fax Number: _____

Date of Symptom Onset: _____ Date of Positive PCR/Anitgen Test: _____

should be ≤ 10 days

REGEN-COV is intended for symptomatic patients at high risk of severe/critical disease from COVID-19. Please refrain from referring asymptomatic patients, and those who are unlikely to require hospitalization for their current illness.

CHECK ALL THAT APPLY:

- ☐ Body Mass Index > 25
- ☐ Pregnancy
- ☐ Sickle Cell Disease
- ☐ Chronic Kidney Disease
- ☐ Diabetes mellitus
- ☐ Immunosuppressive Disease
- ☐ Currently Receiving immunosuppressive Treatment
- ☐ >=65 years of age
- ☐ Cardiovascular disease (CAD, HTN, etc)
- ☐ COPD/other chronic respiratory disease (asthma, etc)
- ☐ Neurodevelopmental Disorder
- ☐ Medical related dependence (tracheostomy, PEG, etc)
- ☐ Other (including race, ethnicity, etc. comment required) _____

_____

_____

COVID-19 Vaccination Status:

- ☐ Fully Vaccinated (Date of last vaccine _____)
- ☐ Partially Vaccinated (Date of last vaccine _____)
- ☐ Not Vaccinated

EXCLUSIONS:

Any patient <18 years of age should be referred to Arkansas Children's Hospital
REGEN-COV is not authorized for patients with an increased O2 requirement.

To discuss a possible referral during business hours, call 202-4630
To complete referral please fax this form and a face sheet to 202-4635
(A recent clinic note and copy of PCR results are also helpful)

Baptist Health