



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:	<input type="text"/>	First Name:	<input type="text"/>
Street Address:	<input type="text"/>	City:	<input type="text"/>
Postal Code:	<input type="text"/>	Phone #:	<input type="text"/>
HCN & VC:	<input type="text"/>	DOB:	<input type="text"/>

## 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
<b>Questions 1-8 MUST be answered 'Yes' and questions 9-10 MUST be answered 'No' in order for this referral to be processed.</b>			
1. Patient is 18 years of age or older.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Patient has a working telephone.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Patient is eligible/qualifies for Remdesivir treatment as per OH/MOH Guidelines.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Patient lives within 30 minutes of a hospital emergency department from the medication administration address.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Patient's current medication list is attached.	<input type="checkbox"/>	<input type="checkbox"/>	
7. Patient's most recent (within 3 months) Bloodwork is attached, including LFT, AST, Cr, eGFR.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Patient has a history of anaphylaxis, anaphylaxis of unknown origin or other medication allergies.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Patient has serious allergies, adverse reactions or anaphylactic reactions to the ordered medication, or related drug.	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL INFORMATION			
<input type="checkbox"/> Vascular Access NOT in place prior to referral – please include orders here: <a href="#">Click or tap here to enter text.</a>			
<input type="checkbox"/> Vascular access in place prior to referral – Date Inserted: <a href="#">Click or tap to enter a date.</a>			
Type of Access:			
<input type="checkbox"/> Peripheral Line – Needle Gauge/Size: <a href="#">Click or tap here to enter text.</a>			
<input type="checkbox"/> Midline			
<input type="checkbox"/> Implanted Port			
<input type="checkbox"/> Central Line - Number of Lumens: <a href="#">Click or tap here to enter text.</a> Inserted Length (cm): <a href="#">Click or tap here to enter text.</a>			
<input type="checkbox"/> Satisfactory position of central line/port/PICC confirmed on chest x-ray.			
CLINICAL INDICATION FOR MEDICATION			
<input type="checkbox"/> Symptomatic for COVID-19. Symptom onset date: <a href="#">Click or tap to enter a date.</a>			
<input type="checkbox"/> Tested positive for COVID-19. Date testing done: <a href="#">Click or tap to enter a date.</a>			
Type of Testing: <input type="checkbox"/> Rapid Antigen Test (RAT) <input type="checkbox"/> Polymerase Chain Reaction (PCR) Test			
MEDICATION ORDERS			
Medication	Route	Dose/Instructions	Initials
Remdesivir	IV	<input type="checkbox"/> 3 day dose: 200mg on Day 1, 100mg on Days 2 & 3	
Remdesivir	IV	<input type="checkbox"/> 2 day dose: 100 mg on Days 2 & 3 - First dose administered on: <a href="#">Click or tap to enter a date.</a>	
Remdesivir	IV	<input type="checkbox"/> 1 day dose: 100mg on Day 3 - First dose administered on: <a href="#">Click or tap to enter a date.</a>	
REFERRER DETAILS			
Printed Name: <a href="#">Click or tap here to enter text.</a>		Signature/Designation: <a href="#">Click or tap here to enter text.</a>	
Phone #: <a href="#">Click or tap here to enter text.</a>		Fax #: <a href="#">Click or tap here to enter text.</a>	
		Date: <a href="#">Click or tap to enter a date.</a>	