CARILION CLINIC

Monoclonal Infusion Therapy External Referral

Fax completed form and documents to 540-857-5233

PATIENT INFORMATION

Patient's Full Name _____ Sex _____ Date of Birth _____

Street Address _____ SSN _____

City, State, Zip Code _____ Phone _____
BEST CONTACT

Requested Infusion Location: _____

REQUESTING PROVIDER

Provider Name _____ Office Phone _____

Street Address _____ Office Fax _____

City, State, Zip Code _____ Cell Phone _____

PATIENT ELIGIBILITY Date of positive COVID test: _____ Onset of symptoms less than 10 days? Yes No

*** **STOP** if greater than 10 days from onset of symptoms – patient is ineligible for monoclonal infusion therapy ***

Please check the appropriate boxes below and add for total score.

BMI	☐ 1 pt = BMI 35–38 ☐ 2 pts = BMI 39 or higher
Chronic Kidney Disease	☐ 1 pt = CKD4 with a GFR of 15–29 ☐ 3 pts = CKD5 with a GFR <15 or dialysis
DM Criteria	☐ 1 pt = DM with an HgbA1C <9 ☐ 2 pts = DM with an HgbA1C of 9 or higher
Immunosuppressive Disease	☐ 4 pts = Primary immunodeficiency or HIV w/ CD4<20%
Immunosuppressive Therapy	☐ 4 pts = Immunosuppressive therapy, transplant patient, chemotherapy, rituximab, biologic therapy, chronic steroids >10 mg prednisone/day
Patient Age	☐ 0 pt = Age: < 55 ☐ 1 pt = Age: 55–64 ☐ 2 pts = Age: 65–70 ☐ 3 pts = Age: 71+
CAD/Stroke	☐ 1 pt = Hx of CAD or Stroke
Respiratory Disease	☐ 1 pt = COPD/Asthma ☐ 3 pts = Cystic fibrosis/severe ILD requiring baseline oxygen ☐ 2 pts = COPD/Asthma with Home O2 Therapy
Symptom Onset	☐ 2 pts = Symptom onset 5 days or less ☐ 1 pt = Symptom onset 6–10 days
TOTAL SCORE	_____ Score must be 5 or greater

☐ Abbreviated H&P w/ past medical history & medication list attached ☐ If available: COVID test result attached

Provider Signature _____ Date _____

PATIENT IDENTIFICATION

CARILION CLINIC

CFMH CGCH CMC - CRMH CMC - CRCH CSJH CNRV CTCH

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CHART-5003