Atmed Urgent Care Johnston
Fax : 401-273-2339
Phone: 401-273-9400

Atmed Urgent Care East Greenwich
Fax: 401-398-8767
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Atmed Urgent Care

Monoclonal Antibody Infusion Referral Form

Patient Name: _____ Referring Provider: _____

Date of Birth: _____ Referring Provider Phone: _____

Patient Phone: _____ Referring Provider Address: _____

Provider has reviewed FDA EUA with patient (Bamlanivimab) (Casirivimab/Imdevimab)

☐ Yes ☐ No

Covid19 related information:

Date of symptom onset: _____ **Vaccinated: ☐ Yes ☐ No**

Date of positive test: _____

Is patient on home oxygen: ☐Yes ☐No

If yes, what is the patient's baseline oxygen requirement _____L/min

Relevant Medical History

Patient's weight: _____ Patient's height: _____

Medications: _____

Allergies: _____

Relevant Past Medical History: _____

Please check if patient has a history of any of the following:

- ☐ Age greater than or equal to 65
- ☐ Body Mass Index (BMI) greater than or equal to 35
- ☐ Cardiovascular disease
- ☐ Hypertension
- ☐ Chronic obstructive pulmonary disease or other chronic lung disease
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease (not including diabetes)
- ☐ Use of immunosuppressive agents