Dear Provider: Thank you for referring your patient for monoclonal antibody infusion as an outpatient treatment for COVID-19. Please supply the following information for our team to be able to assess your referral. Final determination of which monoclonal antibody your patient receives will be determined by the administering institution. For Lifespan referral fax to 401-793-4351.

Basic demographic information

Patient Name: _____

Date of Birth: _____ Age: _____ Telephone: _____

Preferred Language: _____

Referring Provider's name: _____

Referring Provider's phone number: _____

Referring Provider's address: _____

Is the patient ambulatory and can the patient walk up four steps? ☐ Yes ☐ No

Provider has reviewed FDA EUA with patient (Bamlanivimab) (Casirivimab/imdevimab) ☐ Yes ☐ No

COVID19 related information

Date of symptom onset: _____

Date of positive test for SARS-CoV-2 (COVID-19): _____

Is the patient on home oxygen at baseline? ☐ Yes ☐ No

If yes, what is the patient's baseline oxygen requirement? _____ L/min

What is the patient's current oxygen requirement? ☐ None (room air) ☐ _____ L/min

Relevant Medical History

Patient's weight (kg): _____ Patient's height (inches): _____ BMI: _____

Current medications: _____

Allergies: _____

Past Medical History: _____

Is the patient pregnant? ☐ Yes ☐ No

Please check if patient has history of any of the following

- ☐ Age ≥ 65
- ☐ Body Mass Index (BMI) ≥ 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