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healthcare and true care™

COVID-19 Treatment Referral Form

All treatment options are subject to the criteria outlined below
Therapeutic treatment determination is at Infectious Disease provider discretion
May include oral or infusion therapy

Date of Request: __/__/__

Patient Name: ____Date of Birth: __/__/__
Telephone Number: (____) ____________ Street Address: ______________________________ Apt #: _________
City: _______________________ State: ___________________Zip: _____________
Insurance Carrier: ___________________ ID #: ____________________ Group #:_________________

Treatment of mild to moderate COVID-19 infection in patients with positive results of direct SARS-CoV-2 viral testing and who are at high risk for severe COVID-19 and/or hospitalization

Exclusion Criteria for Outpatient COVID-19 Treatment:
Recent hospitalization and/or requiring hospitalization due to COVID-19
New or increased oxygen requirement due to COVID-19
COVID-19 symptom onset > 10 days ago

Please Select Applicable Criteria	**Inclusion Criteria for Outpatient COVID-19 Treatment:** (minimum of 2 criteria required; > 3 criteria preferred)
	Unvaccinated individuals
	Age ≥ 65
	Age ≥ 55 **AND** cardiovascular disease, hypertension, chronic obstructive pulmonary disease, or other chronic respiratory diseases
	BMI ≥ 35
	Chronic Kidney Disease
	Diabetes
	Pregnancy
	Immunosuppression

Referring Provider Name: ____ Contact #: _____________________
Referring Provider Signature: _____________________________________ Date: __/__/__ Time: ____________

Please email referrals to jclaus@ecmc.edu, jsabatino@ecmc.edu, lrossi@ecmc.edu