Place Patient Label
Inside This Box

Referral for Bamlanivimab Infusion

Subject to Availability

Patient Name: _____ DOB: _____/_____/_____

Phone Number: _____ Allergies: _____

Height: _____ Weight: _____

Must be Positive for COVID-19 and within 5 days of symptoms onset

Date of Positive COVID Test: _____/_____/_____ Testing Site: _____

Date of Symptom Onset: _____/_____/_____ ICD 10 Diagnosis Code: U07.1

Exclusion Criteria: Use of supplemental oxygen, hospitalization

Mark All Applicable Indications

Must meet at least one criteria:

- BMI ≥ 35
- ≥ 65 years of age
- Diabetes
- Immunosuppressive disease
- Currently receiving immunosuppressive treatment
- Chronic kidney disease
- Age is ≥ 55 years AND has:
  - Cardiovascular disease OR
  - Hypertension OR
  - Chronic Obstructive Pulmonary Disease/Other Chronic Respiratory Disease

Completion of Referral

☐ Patient received *Bamlanivimab Fact Sheet for Patients, Parents, and Caregivers*

Provider Name: _____

Phone Number: _____

Provider Signature: _____ Date:_____ /_____ /_____ Time: _____

Fax Completed Referral Form to 910-571-5364, Attn: Charge Nurse
Please call 910-571-5360 with questions or concerns