HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Sud-Ouest

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Adult Intravenous Remdesivir Infusion Therapy Order Form

Patient information

Surname		First Name
Home Address		
City		Postal Code
Health Card Number	Version Code	Date of Birth (DD-Month-YYYY)
Phone Number		Other

****Intravenous (IV) Remdesivir is available for administration in Community Nursing Clinic only.****

Form Instructions

Complete and fax to Home & Community Care Support Services South West at
1-519-472-4045 or **1-855-223-2847**

Orders are processed between **8am – 8pm (7 days/week)** and require a minimum 4-hour turnaround window.
Referral form must be completed in full to permit processing. Incomplete orders will be returned.
HCCSS SW uses a 'Clinic First' approach to service delivery.

The following must be sent along with a completed copy of this form:

- Recent blood laboratory values required, taken in the last 3 months (HCCSS SW not involved in requesting/ ordering bloodwork); Liver function tests, Aspartate Aminotransferase (AST), Creatinine, estimated Glomerular Filtration Rate (eGFR)
- Current medication list

Note: Determining and providing proof of patient eligibility for IV Remdesivir therapy is the Prescriber's responsibility.

Remdesivir cannot be administered in patients with renal impairment (eGFR <30 ml) or with liver impairment (with ALT ≥5 × ULN). Refer to product monograph for specific details related to lab values.
https://covid-vaccine.canada.ca/info/pdf/veklury-pm1-en.pdf

Medical Information

Drug allergies (list ALL) ☐ No known drug allergies

Vascular Access

☐ In place: Vascular Access established prior to referral
Type of Access: ☐ Peripheral Line ☐ Midline ☐ Implanted Port ☐ Central Line
Date Inserted (DD-Month-YYYY): _____ Needle Gauge/Size: _____
(Required for Central Line only) Number of lumens: _____ Inserted length (cm): _____
☐ Satisfactory position of central line/port/PICC confirmed on chest x-ray
☐ Required: Peripheral Vascular Access to be established in Community Nursing Clinic

Note:
1. Nursing will change and manage peripheral IV line access, flushing, dressings and maintenance as per agency protocol.
2. Nursing will manage central IV line access, flushing, dressings and maintenance as per routine agency protocol unless otherwise instructed.

Ontario

Surname	First Name	Health Card Number

Medication Orders

Clinical Indication for Medication
Symptomatic for COVID-19 - Tested Positive for COVID-19
Requires IV Remdesivir Treatment - Not eligible for Paxlovid

Symptom Onset Date (YYYY-Month-DD)	Date COVID-19 Testing Done (DD-Month-YYYY)	Type of Testing Done
		☐ COVID RAT ☐ COVID PCR

Treatment Orders

☐ IV Remdesivir Standard Protocol: IV Remdesivir 200mg once on Day 1 then IV Remdesivir 100mg once daily x 2 days

OR

☐ IV Remdesivir Specific Protocol: (please provide instructions) _____

First Dose of IV Remdesivir Standard Protocol Received (DD-Month-YYYY)	Requested Treatment Start Date (DD-Month-YYYY)	Requested Treatment End Date (DD-Month-YYYY)

Flush Protocol Orders

☐ _____ (orders)

☐ As per Nursing Remdesivir policy

Special Instructions

HCCSS SW First Dose IV Remdesivir Screener (adapted from HCCSS Provincial Parenteral Screener)

When requesting first dose IV Remdesivir please complete risk assessment questions below.
If the patient has taken the prescribed medication in the past six (6) months without reaction, please answer all questions except for 2, 3, and 4.

	Yes	No
1. The patient is younger than 18 years old.	☐	☐
2. The patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound.	☐	☐
3. The patient has a history of anaphylaxis of unknown origin or serious allergies.	☐	☐
4. The patient is taking a beta blocker.	☐	☐
5. The patient does not have someone 18+ years available to monitor/stay with patient for first 6 hours post medication administration.	☐	☐
6. The patient does not have access to a working telephone.	☐	☐
7. The patient does not have access to Emergency Medical Service or hospital within thirty (30) minutes.	☐	☐
8. The patient is taking one of the following: Chloroquine, Hydroxychloroquine or Rifampin.	☐	☐

If a 'Yes' answer is for any of the questions above, Nursing Service Provider and Prescriber will review and determine if treatment should continue in the community nursing clinic setting.

Referrer Details

Referrer Name	CPSO/CNO Registration	OHIP Billing Number

Phone Number	Fax Number

Office Address

City	Postal Code

Referrer Signature	Date Signed (DD-Month-YYYY)