ANDREWS COUNTY HEALTH DEPARTMENT

Outpatient Monoclonal Antibody Infusion Protocol

Lincoln Center 400 NE Ave J, Andrews, TX 79714 **Phone: (432) 523-2590 Fax: (432) 400-3175**

Patient Name: _____

Patient DOB: _____

Patient Phone Number: _____

Patient Allergies: _____

TO ORDER: SEND THE FOLLOWING DOCUMENTATION VIA EMAIL: INFUSIONCENTER@CO.ANDREWS.TX.US

- **THIS COMPLETED ORDER FORM**
- **POSITIVE COVID TEST DOCUMENTATION**
- **H&P OR DOCTORS VISIT DOCUMENT EXPLAINING HOW PATIENT MEETS CRITERIA**

NOTE: Patient must **NOT** be hospitalized, require oxygen therapy **OR** require an increase in oxygen rate due to Covid-19 if using for underlying comorbidity **AND** within 10 days of symptom onset.

PATIENT INCLUSION CRITERIA– CHECK ALL THAT APPLY:

- ☐ ≥ 65 years of age
- ☐ BMI (body mass index) ≥ 25 **OR** if age 12-17 and BMI ≥ 85th percentile for age and gender based on CDC growth charts.
  - Height: _____
  - Weight: _____
- ☐ Pregnancy
- ☐ Chronic Kidney Disease
- ☐ Diabetic
- ☐ Immunosuppressive Disease
  - Type: _____
- ☐ Receiving Immunosuppressive Treatment
  - Type:_____>_____
- ☐ Cardiovascular disease (hypertension or congenital heart disease)
- ☐ Chronic Lung Diseases (COPD, asthma (moderate-severe), cystic fibrosis, pulmonary hypertension, or interstitial lung disease)
- ☐ Sickle Cell Disease
- ☐ Neurodevelopmental disorders (ex. cerebral palsy,) or other conditions that confer medical complexity (ex. genetic or metabolic syndromes and severe congenital anomalies).
- ☐ Having a medical related technological dependence (ex. tracheostomy gastrostomy, or positive pressure ventilation not related to COVID).

CONFIRMED COVID POSITIVE DATE: _____

TYPE OF TEST:

PCR ☐ **ANTIGEN** ☐

SYMPTOM ONSET DATE: _____

Patient risk factors will be evaluated and scheduled based on available drug allocation and prescriber will be notified of outcome.

PHYSICIAN SIGNATURE: _____

DATE: _____ **TIME:** _____

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