TO SCHEDULE APPOINTMENT PLEASE CALL: 702-961-9075

Sunrise Hospital Bamlanivimab Infusion Screening Form

Patient Name: _____ **Todays Date:** _____/_____/_____

D.O.B.: _____/_____/_____ **Screening Location:** _____

Cell Phone: _____ **Email address**: _____

Address: _____ **Zip Code:** _____

Onset of mild to moderate COVID-19 symptoms: _____/_____/_____

Symptoms less than 10 days? ☐ yes ☐ **no** STOP **NOT ELIGIBLE**

SpO2_____% > 90% ☐ *yes* ☐ ***no*** STOP ***NOT ELIGIBLE***
With no new or increase O^2

Stable for discharge home: ☐ *yes* ☐ ***no*** STOP ***NOT ELIGIBLE***

Symptoms_____

High risk is defined as a patient who ***meets at least one*** of the following criteria: (check all that apply)

☐ BMI ≥ 35 ☐ Chronic kidney disease ☐ Diabetes ☐ Immunosuppressive disease

☐ currently receiving immunosuppressive treatment ☐ Are ≥ 65 years of age

☐ Are ≥ 55 years of age **AND** ☐ Cardiovascular disease, **OR** ☐ Hypertension, **OR**

☐Chronic obstructive pulmonary disease / other chronic respiratory disease

If eligible on screening criteria of duration, pulse oximetry, outpatient treatment **AND** one or more high risk factors checked above, **patient must have a positive COVID test (either documented prior test or rapid test today)**.

Date of COVID test: _____/_____/_____ COVID test result positive ☐ yes ☐ **no** STOP **NOT ELIGIBLE**

Positive Test Type: ☐ PCR ☐ Antigen

Infusion Appointment: _____/_____/_____ at _____:_____ (**must be within 10 days of symptoms onset**)

☐ Administer Bamlanivimab intravenous (IV) infusion of 700 mg over 60 minutes via pump or gravity.

Physician/APP: Print_____ Signature_____

Provide patient with mAB instruction sheet, directions for infusion center and discharge.

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