**Bamlanivimab/Etesevimab Infusion Patient Screening Form**



**Pediatric Age 12-17**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**D.O.B.: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset of mild to moderate COVID-19 symptoms: \_\_\_\_\_/\_\_\_\_\_\_ / \_\_\_\_\_\_

Weight ≥ 40kg? □ yes □ **no** – ****  **NOT ELIGIBLE**

Symptoms less than 10 days? □ yes □ **no** – ****  **NOT ELIGIBLE**

SpO2\_\_\_\_\_\_\_\_% > 90%  *□ yes □* ***no*** *–* **** ***NOT ELIGIBLE***

With no new or increase O2

Stable for discharge home: *□ yes □* ***no*** *–* **** ***NOT ELIGIBLE***

Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pediatric** high risk is defined as a patient who is ***12-17 years of age*** **AND** ***meets at least one*** of the following criteria: (check all that apply)

□ BMI > 85th percentile for their age and gender based on CDC growth charts, <https://www.cdc.gov/growthcharts/clinical_charts.htm> ,

 □ Asthma, reactive airway or other chronic respiratory disease that required daily medication,

 □ Sickle Cell Disease,

□ Congenital or acquired heart disease,

□ Neurodevelopmental disorders, for example, cerebral palsy,

□ Medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)

□ Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control.

□ Inflammatory bowel disease on systemic corticosteroid (but not on TNF antagonist) therapy

Date of COVID test: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ COVID test result positive □ yes □ **no**  **NOT ELIGIBLE**

Positive Test Type: □ PCR □ Antigen

□ **Administer Bamlanivimab 700 mg + Etesevimab 1400 mg intravenous (IV) infusion.**

Physician/APP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print name Signature

 Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provide patient with instructions, and copy of screening form and Map with directions to infusion center.**