COVID-19 MONOCLONAL ANTIBODIES SELF-SCREENING PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________________

Gender: ☐ Male ☐ Female Phone: ____________________ Email: ______________________________

Address: ______________________________ City: ________________ State: _____ Zip: ________

Healthcare Provider Name: __________________________ Heathcare Provider Phone: ________________

Which of the following best describes your racial or ethnic identity? Please check all that apply:

☐ Black/African American ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ Asian

☐ Native Hawaiian/Pacific Islander ☐ Middle Eastern/North African ☐ White ☐ Other ☐ Not Specified

Do you have a disability? ☐ Yes ☐ No

Height: ______________ Weight: ______________

INSURANCE INFORMATION

☐ **Medicaid:**

Medicaid Provider: ______________________________ Policy/Member ID #: ______________________

Medicaid #: __________________________ Group #: __________________________

☐ **Medicare Part B:**

Subscriber ID #: ____________________________ Responsible Party: ____________________________

Policy Holder's Date of Birth: __________________________

☐ **Private Insurance:**

Insurance Provider: ______________________________ Member ID: __________________________

Bin #: ____________________ PCN: ____________________ Group #: ____________________

☐ **No Insurance**

PLEASE COMPLETE SCREENING QUESTIONS ON BACK

SCREENING QUESTIONS

	YES	NO	DON'T KNOW
Are you under 12 years old?	☐	☐	☐
Do you weigh under 88lbs?	☐	☐	☐
Have you had a positive COVID-19 antigen test within the past 14 days? If yes, please indicate the date of the positive test: ________________.	☐	☐	☐
Have you been in close contact with someone with COVID-19 within the last 96 hours (4 days), or living in a setting where risk of exposure is high? If yes, date of exposure: ____	☐	☐	☐
In the past 10 days, have you experienced new or worsening of any of the following symptoms? If yes, select all that apply: ☐ Fever ☐ Chills ☐ Cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Fatigue ☐ Headache ☐ Muscle or body aches ☐ New loss of taste or smell ☐ Sore throat ☐ Congestion ☐ Runny nose ☐ Nausea ☐ Vomiting ☐ Diarrhea Date of symptom onset: ____	☐	☐	☐
Are you fully vaccinated for COVID-19? If yes, which vaccine did you receive? _________________ Date of first dose: _______________ If applicable: Date of second dose: _______________ Date of third dose: _________________	☐	☐	☐
Are you 65 years of age or older?	☐	☐	☐
Do you have cancer?	☐	☐	☐
Do you have chronic kidney disease?	☐	☐	☐
Do you have a chronic lung disease? (ex: moderate to severe asthma, cystic fibrosis, COPD, pulmonary hypertension, interstitial lung disease)	☐	☐	☐
Do you have dementia or other neurological condition?	☐	☐	☐
Do you have diabetes (Type 1 or Type 2)?	☐	☐	☐
Do you have a heart condition (ex: heart failure, coronary artery disease, cardiomyopathies, hypertension)	☐	☐	☐
Do you have HIV?	☐	☐	☐
Are you immunocompromised?	☐	☐	☐
Do you have liver disease?	☐	☐	☐
Do you have a neurodevelopmental disorder (ex: cerebral palsy, intellectual or developmental disabilities including down syndrome) or other condition that confers medical complexity (ex: genetic or metabolic syndromes and severe congenital anomalies)?	☐	☐	☐
Do you have a medical-related technological dependence (ex: tracheostomy, gastrostomy, oxygen supplementation not related to COVID-19)	☐	☐	☐
Are you overweight or obese?	☐	☐	☐
Are you pregnant?	☐	☐	☐
Do you have sickle cell disease or thalassemia?	☐	☐	☐
Are you a smoker or do you have a history of smoking?	☐	☐	☐
Have you ever had a stroke or cerebrovascular disease, which affects blood flow to the brain?	☐	☐	☐
Have you had a solid organ or blood stem cell transplant?	☐	☐	☐
Do you have a substance use disorder?	☐	☐	☐
Do you have any other medical problems? If yes, please explain: ____	☐	☐	☐
Are you allergic to casirivimab, imdevimab, histidine, histidine monohydrochloride monohydrate, polysorbate 80, or sucrose? If yes, please specify: ________________________	☐	☐	☐
Do you have any other allergies? If yes, please explain: _______________________________	☐	☐	☐
Do you take any medication including herbs or supplements? If yes, list them here: ____	☐	☐	☐

Patient Signature: ____ Date: ______________________________