



fraserhealth

# COVID-19 THERAPY INFECTIOUS DISEASE CONSULT MEDICAL DAY CARE (MDC) – OUTPATIENT REFERRAL



Form ID: MSXX107569B

Rev: February 16, 2022

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**FAX to: JPOCSC MDC 604-582-3742**

### Patient Information:

Patient Last Name:		Patient First Name:	
Patient Middle Name:		Gender:	
Date of Birth (DD/MM/YYYY):		PHN:	Insurance:
Address:			
City:	Province:	Postal Code:	
Contact Method Primary:		Alternate:	

### Referral Information:

<b>Medical History:</b>		
<b>Eligibility Criteria:</b>		
<input type="checkbox"/> Confirmed mild COVID-19. Date positive COVID-19 test: _____ <b>*AND*</b>		
<input type="checkbox"/> Symptomatic for 7 days or less. Date of symptom onset: _____ <b>*AND*</b>		
At least one of the following criteria for high-risk disease:		
<input type="checkbox"/> Immunocompromised individuals identified as clinically extremely vulnerable (CEV) group 1 and group 2, regardless of vaccine status or previous infection		
<input type="checkbox"/> Unvaccinated or partially vaccinated individuals identified as CEV group 3		
<input type="checkbox"/> Unvaccinated or partially vaccinated individuals age 70 years and older with one or more chronic condition/co-morbidity (e.g., obesity, diabetes, heart failure, chronic lung disease, chronic kidney disease; other chronic conditions can be considered)		
<input type="checkbox"/> Unvaccinated or partially vaccinated individuals age 60 years and older with three or more chronic conditions/co-morbidities		
<input type="checkbox"/> Unvaccinated or partially vaccinated individuals age 60 years and older who are Indigenous		
<input type="checkbox"/> Unvaccinated or partially vaccinated pregnant individuals with additional risk factors		
<b>Vaccination History:</b>		
Date of 1st vaccine dose:	Date of 2nd vaccine dose:	Date of booster:
<b>Allergies:</b>		

Date: (dd/mmm/yyyy)	Prescriber Name:	Phone #: _____ Fax #: _____	Signature:	College ID# (MSP)
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