fraserhealth

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

Form ID: MSXX107569B Rev: February 16, 2022 Page: 1 of 1

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:

Medical History:

Eligibility Criteria:

☐ Confirmed mild COVID-19. Date positive COVID-19 test: _____

AND

☐ Symptomatic for 7 days or less. Date of symptom onset: _____

AND

At least one of the following criteria for high-risk disease:

☐ Immunocompromised individuals identified as clinically extremely vulnerable (CEV) group 1 and group 2, regardless of vaccine status or previous infection

☐ Unvaccinated or partially vaccinated individuals identified as CEV group 3

☐ 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)

☐ Unvaccinated or partially vaccinated individuals age 60 years and older with three or more chronic conditions/co-morbidities

☐ Unvaccinated or partially vaccinated individuals age 60 years and older who are Indigenous

☐ Unvaccinated or partially vaccinated pregnant individuals with additional risk factors

Vaccination History:

Date of 1st vaccine dose:	Date of 2nd vaccine dose:	Date of booster:

Allergies:

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