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| --- | --- | --- | --- | --- | --- |
| **CORNWALL COVID ANTIVIRAL MEDICINE REFERRAL FROM**  **For completion by referring clinician** | | | | | |
| Patient Name |  | | | | |
| DOB |  | | Age (must be >18) | |  |
| NHS No |  | | | | |
| Home Address |  | | | | |
| Pt Contact No |  | | | | |
| GP Practice |  | | | | |
| Today’s Date |  | | | | |
| Covid +ve Test Date |  | | | | |
| Referred By |  | | | | |
| Referrer phone no |  | | | | |
| Referrer email |  | | | | |
| Symptom Onset Date |  | | | | |
| Qualifying Medical Criteria  <https://www.nhs.uk/conditions/covid-19/treatments-for-covid-19/> | Down’s Syndrome | Severe Liver disease | | | |
| Sickle Cell Disease | Primary immune deficiency | | | |
| Solid cancer | HIV/AIDS | | | |
| Haematological malignancy | Solid organ transplant recipient | | | |
| Renal disease (CKD 4 or 5) | Immune-mediated inflammatory disorders (IMID) | | | |
| Rare neurological condition | Lung disease | | | |
| Other – specify below | | | | |
|  | | | | |
| Past Medical History |  | | | | |
| **ALL** Current Medications |  | | | | |
| Allergies |  | | | | |
| Latest EGFR | Value: | | | Date: | |
| Latest LFTs | Values: | | | Date: | |
| On completion, email to [ciosicb.cmdu@nhs.net](mailto:ciosicb.cmdu@nhs.net)  Patients will be contacted by telephone no later than the next working day  **PLEASE NOTE THAT THIS IS A MONDAY – FRIDAY SERVICE ONLY** | | | | | |

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