NORTH CENTURY PHARMACY
COLUMBIA, KENTUCKY
3058 Campbellsville Rd. 270.380.1230

COVID-19 Monoclonal Antibodies Self-Screening Patient Intake Form

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Gender: ☐Female ☐Male **Phone:** _____ **Email:** _____

Home Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

SSN: _____ **Healthcare Provider Name:** _____ **Provider Phone Number:** _____

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

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

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

Do you have a disability? ☐Yes ☐No

SCREENING QUESTIONS

1. Do you take any medication including herbs or supplements?	☐Yes ☐No ☐Don't know
2. Have you had a positive COVID-19 test within the past 14 days?	☐Yes ☐No ☐Don't know
3. Have you been in close contact with someone with COVID-19 within the last 96 hours (4 days), or living in a setting with risk of exposure is high?	☐Yes ☐No ☐Don't know
4. Are you fully vaccinated for COVID-19?	☐Yes ☐No ☐Don't know
5. Do you have cancer?	☐Yes ☐No ☐Don't know
6. Do you have chronic kidney disease?	☐Yes ☐No ☐Don't know
7. Do you have a chronic lung disease?	☐Yes ☐No ☐Don't know
8. Do you have dementia or other neurological condition?	☐Yes ☐No ☐Don't know
9. Do you have diabetes?	☐Yes ☐No ☐Don't know
10. Do you have a heart condition?	☐Yes ☐No ☐Don't know
11. Do you have HIV?	☐Yes ☐No ☐Don't know
12. Are you immunocompromised?	☐Yes ☐No ☐Don't know
13. Do you have liver disease?	☐Yes ☐No ☐Don't know
14. Do you have a neurodevelopment disorder or other condition that confers medical complexity?	☐Yes ☐No ☐Don't know
15. Do you have a medical-related technological dependence (ex: tracheostomy, oxygen)?	☐Yes ☐No ☐Don't know
16. Are you overweight or obese?	☐Yes ☐No ☐Don't know
17. Are you pregnant?	☐Yes ☐No ☐Don't know
18. Do you have sickle cell disease or thalassemia?	☐Yes ☐No ☐Don't know
19. Are you a smoker or do you have a history of smoking?	☐Yes ☐No ☐Don't know
20. Have you ever had a stroke or cerebrovascular disease, which affects blood flow to the brain?	☐Yes ☐No ☐Don't know
21. Have you had a solid organ or blood stem cell transplant?	☐Yes ☐No ☐Don't know
22. Do you have a substance use disorder?	☐Yes ☐No ☐Don't know
23. Do you have other medical problems?	☐Yes ☐No ☐Don't know
24. Are you allergic to casirivimab, imdevimab, histidine, histidine monohydrochloride monohydrate, polysorbate 80, or sucrose?	☐Yes ☐No ☐Don't know

25. In the past 10 days, have you experienced new or worsening of any of the following symptoms? Please select all that apply:

☐ fever ☐ chills ☐ cough ☐ shortness of breath ☐ difficulty breathing ☐ fatigue ☐ headache ☐ sore throat

☐ muscle or body aches ☐ new loss of taste or smell ☐ congestion ☐ runny nose ☐ vomiting ☐ diarrhea

Date of positive COVID-19 test (If applicable): _____

Date of COVID-19 exposure (If applicable): _____

Date(s) of COVID-19 vaccine(s) (If applicable): _____ ☐ J&J/Janssen ☐ Moderna ☐ Pfizer-BioNTech

I understand the benefits and risks of the monoclonal antibody treatment, as described in the **Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA)**, a copy of which I was provided with this Consent and Release. I understand that I will get the opportunity to ask questions about the vaccine prior to administration. I request that the treatment be given to me or to the person named above, a minor for whom I represent and for whom I am authorized to sign this Consent and Release.

Signature: _____ **Date:** _____

(Parent or guardian, if minor)

HEALTHCARE PROVIDER ONLY

HEIGHT	WEIGHT	BMI	BP	PR	RR	O2	TEMP