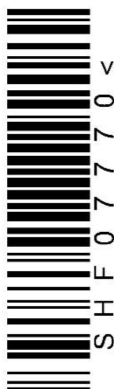
Monash Health Sotrovimab Clinic Referral
Please send to Sotrovimab@MonashHealth.org

Monash Health



Date of Referral: _____ / _____ / _____

Patient Details	**Monash Health UR:** _______________

Name: ____ D.O.B: _____ / _____ / _____

Address: ____

Medicare number: ___________________________

Contact Number: ___________________________ Email Address: ________________________________

Best contact details (time/method): ________________________________

Secondary Contact Name: _____________________ Number: ________________________________

Interpreter Required? ☐ Yes ☐ No Language: ________________________

Patient Triage		
Positive COVID-19 throat/nasopharyngeal PCR test	☐ Yes	☐ No
Date of symptom onset **(Please Specify Date)** ____________		
Has had less than 5 days of symptoms **(Note: First day of symptoms is day 0)**	☐ Yes	☐ No
Incomplete vaccination	☐ Yes	☐ No
Does not require oxygen	☐ Yes	☐ No
One or more of the following risk factors:		
• Age > 55	☐ Yes	☐ No
• Diabetes (requiring medication)	☐ Yes	☐ No
• Obesity (BMI > 30 kg/m²)	☐ Yes	☐ No
• Chronic Kidney Disease (eGFR < 60)	☐ Yes	☐ No
• Congestive heart failure (NYHA class II or greater)	☐ Yes	☐ No
• COPD	☐ Yes	☐ No
• Asthma (moderate to severe)	☐ Yes	☐ No
Immunocompromised (regardless of vaccination)	☐ Yes	☐ No
• Active leukaemia or lymphoma		
• HIV		
• Solid-organ transplant or haematopoietic stem cell transplant less than 2 years ago		
• Taking immunosuppressive therapy		
• Aplastic anaemia		
Meets criteria for Sotrovimab	☐ Yes	☐ No
Patient consented to contact from clinic	☐ Yes	☐ No
Does patient have transport to/from clinic	☐ Yes	☐ No
Is the patient able to self-transfer	☐ Yes	☐ No
Has the patient been approved by an infectious disease clinician?	☐ Yes	☐ No

Name: _______________ Designation: _______________ Contact: _______________

SOTROVIMAB CLINIC REFERRAL

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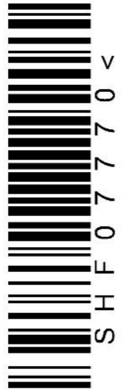

Additional Clinical Information:

Referrers Name: ____________________________________ Designation: _________________________________

Signature: ____ Contact Number: _____________________________

Date of Referral: _____ / _____ / _____

Referrer type: ☐ Monash Health Internal ☐ External Health Service ☐ GP ☐ Other

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