Referral form – FAX TO 902-405-4373

Patient Label

Patient name: _____

DOB: _____

HCN: _____

Patient Address: _____

Patient Phone #: _____

Date of symptom onset: _____

Date of positive COVID-19 test: _____

Pulse oximeter number: _____

Referral source: ☐ Public Health
☐ Emergency Department
☐ Secondary Assessment Centre
☐ Inpatient COVID ward
☐ Primary Care Office
☐ Other _____

Location of referral source: _____

Reason for referral: _____

☐ **Please check to confirm that the patient has verbally consented to being contacted by a research team who will be evaluating this clinic.**

Eligibility Criteria

- Known diagnosis of COVID-19 (positive swab results only, those with pending tests are not eligible to be followed by this team)
- Day 2-14 after symptom onset
- Deemed to be at high risk of clinical deterioration given risk factors AND symptom severity*
- Does not meet criteria for hospital admission
- Does not meet criteria for COVID-19 recovery (at least 10 days after symptom onset AND afebrile with improving symptoms)

*risk factors: age>65, BMI>30, one or more chronic conditions (e.g. heart failure, chronic lung disease, hypertension); severe symptoms: shortness of breath, clinical features of pneumonia.