Indigenous Services Canada / Services aux Autochtones Canada

APPENDIX I: Sotrovimab Client Care Notes:
Side 1: Administration of Sotrovimab Monoclonal Antibody Infusion

Patient Label:
CLIENT NAME (Last name, First name):
_____
AGE: _____ DOB: _____ PHN: _____
Administration location:

Date of Administration: _____ Name of HCP/Designation: _____

Emergency Contact:_____
Weight: _____ (estimate/actual) Height: _____(estimate/actual)

Education Provided:
_____
_____

Client is eligible for sotrovimab treatment: Please specify
☐ Age
☐ Immunocompromised or immunosuppressed
☐ Comorbidity

Mild/Moderate Symptoms Present: _____
_____
_____

Allergy / Intolerance to Medication
☐ No known medication allergies
☐ Medication allergies, as follows:
Drug Name: **Reaction:**
Drug Name: **Reaction:**
Drug Name: **Reaction:**
☐ See attached medication list

Medication Lot #_____

Date of Symptom Onset: _____

· SARS-CoV-2 RT-PCR **PENDING AS OF:** _____
RESULT: · **POS** · **NEG**

· **A**ntigen test **PENDING AS OF:** _____
RESULT: · **POS** · **NEG**

· **N/A**

Date/ Time	Pre (baseline)/ During (q10 mins)/ Post (q 10 mins for one hour post) Infusion	Vital Signs						Describe	Any questions or concerns: *See Progress Notes
		Glasgow Coma Scale (GCS)	Heart Rate	Blood Pressure	Respiratory Rate	O2 saturation	Temperature	Adverse Reaction?	
	Baseline								
	Infusion Start								

Date/Time	Progress Notes