**Patient Label:**

CLIENT NAME (Last name, First name):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ PHN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administration location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX K: Sotrovimab NP Follow-Up:**

**Side 1**: Post Administration Monitoring

Education Provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of HCP/Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ (estimate/actual) Height: \_\_\_\_\_\_\_\_\_\_\_\_\_(estimate/actual)

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| **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 | **Date of Symptom Onset: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****** SARS-CoV-2 RT-PCR **POSITIVE AS OF:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** A**ntigen test **POSITIVE AS OF:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** N/A** |
| **Medication Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date/****Time**  | **Monitoring Day** | **Questions:****Expand on answers in progress notes if required.** | **\*COVID Symptoms:*** Difficulty breathing/ shortness of breath
* Severe chest pain
* Feelings of confusion
* Swelling of face, lips, tongue or other parts of the body
 | **\*\*Side Effects/Delayed Allergic Reaction:*** Diarrhea
* Skin (redness/rash/itchy)
* Fever or chills
* Chest pain/pressure
* Fast, slow or abnormal heartbeat
* Upset stomach, nausea, vomiting
* Throat irritation
 |
| How are you feeling today? (same/better/worse) | Worsening of COVID symptoms?\*Yes/No | Side Effects/ delayed allergic reaction?\*\*Yes/No | Hydration: Food/water intake, voiding adequate? | Other symptoms (not previously mentioned) | Patient Concerns |
|  | Day 1 |  |  |  |  |  |  |  |  |
|  | Day 2 |  |  |  |  |  |  |  |  |
|  | Optional Day 3 |  |  |  |  |  |  |  |  |
|  | Optional Day 4 |  |  |  |  |  |  |  |  |
|  | OptionalDay 5 |  |  |  |  |  |  |  |  |
|  | Other |  |  |  |  |  |  |  |  |

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| **Date/Time** | **Progress Notes** |
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