**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 |  |  |  |  |  | |  |  |  |
|  | Optional  Day 5 |  |  |  |  |  | |  |  |  |
|  | Other |  |  |  |  |  | |  |  |  |

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