Date:_____

Hasbro Children's Hospital & the Tomorrow Fund Clinic

MAB-INTAKE REFERRAL

Phone: 401-444-8360 Fax: 401-444-5650

Basic Demographic Information

Patient Name _____ DOB _____

Aged _____ Preferred Language _____ Phone #_____

Parent/Caregiver names: _____ Alt phone#_____
Address:_____

Referred by _____

Referring Provider's Best Phone # _____

Has the provider discussed treatment caregiver, and they wish to pursue? YES NO

Does the patient have transportation to Hasbro? YES NO

Has the provider reviewed/provided FDA info with the parent(s)? YES NO

COVID-19 Related Information

Date of symptom onset_____ Date of positive test for SARS-CoV2 _____

OR date of COVID-19 exposure _____ Date of negative SARS-CoV2_____

Vaccination status: None_____ Partial _____ Full _____ Date: _____

Is the patient on home oxygen at baseline? YES NO

- If YES, what is the patient baseline oxygen requirement _____ L/min
- If YES, what is the patient's current oxygen need? _____None (room air) _____L/ min

Weight _____ Height _____ Is BMI percentile >85% YES NO

Is the patient pregnant? N/A Unknown YES NO

Allergies _____

Primary risk factor and additional risk factors?_____

Is patient from a vulnerable group? Or non-white race? YES NO

***If possible in referral process, please include patient demographics**