

# Mobile Infusion Strike Team (MIST)

## PATIENT SCREENING & REFERRAL – to be completed by the Facility in Consultation with the Referring Physician

Today's Date: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_

Completed in Consultation  
with Referring Physician

### Referring Physician Information

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Office Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
Physician Email: \_\_\_\_\_ Physician Fax: \_\_\_\_\_


### Patient Information








Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Transportation/Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Do Not Resuscitate (DNR) Status: \_\_\_\_\_

Date of Onset of Illness (Mild to Moderate\*) \_\_\_\_\_ = \_\_\_\_\_ Days of Illness (</=10)

Check all symptoms that are present:

- |                                      |                                      |                                   |                                              |
|--------------------------------------|--------------------------------------|-----------------------------------|----------------------------------------------|
| <input type="checkbox"/> Fever       | <input type="checkbox"/> Malaise     | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Loss of taste/smell |
| <input type="checkbox"/> Cough       | <input type="checkbox"/> Headache    | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dyspnea on exertion |

Date of Testing for COVID: \_\_\_\_\_ Test Type:  Antigen  PCR  No Test  : Not Eligible

- |                                                                                         |                                                          |                                                                                                                                        |
|-----------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| ➤ Is not pregnant                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible                                     |
| ➤ Symptoms present 10 days or less:                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible                                    |
| ➤ spO2% greater than 90% on RA:                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible                                    |
| ➤ Patient has not received, or has only received the first dose of the COVID-19 vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible Date of Second Vaccine Dose: _____ |
| ➤ Is not being admitted to an acute care hospital:                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |  Not Eligible <input type="checkbox"/> N/A         |
| ➤ If previously on supplemental O2, has no increased need                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible                                    |
| ➤ Documented positive COVID test performed                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |  : Not Eligible                                    |

\*NIH Definition: **Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.

**Moderate Illness:** Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have saturation of oxygen (SpO2) ≥90% on room air at sea level

### High Risk Patients Eligible for Care: Risk Score Calculator [Score must be >7\*]

**Risk Score Calculator Monoclonal Antibody Infusion inclusion criteria (please indicate all that apply) \*Note: Residents of Skilled Nursing Facilities qualify regardless of score, but please calculate and record a risk score for tracking purposes:**

#### Highest-Risk Comorbidities (2 points each)

- Diabetes Melitus
- Severely Immuno-compromised
- Obesity (BMI > 30)
- Hypertension
- Coronary Artery Disease
- Cardiac Arrhythmia
- Congestive Heart Failure

#### Other High-Risk Comorbidities (1 point each)

- Chronic Liver Disease
- Cerebrovascular Disease
- Chronic Neurologic Disease
- Chronic Kidney Disease

#### Additional Factors (points vary)

- Male = 1 point
- Non-White Race or Hispanic/Latinex Ethnicity = 2 points
- New Shortness of Breath = 1 point
- Age = 0.5 points for each decade of life (ex: 61-70 years old = 3.5 points)**

Patient Total Risk Score: \_\_\_\_\_

Appointment to infuse scheduled: \_\_\_\_\_ at \_\_\_\_\_ (before 10<sup>th</sup> day since symptom onset)

**\*\*Please complete form and Fax to 385-465-6060 at least 24 hours before MIST arrival. Submit hard copy to MIST upon arrival.\*\***