

Mississauga COVID, Cold and Flu Care Clinics

@ Applewood Hills Plaza
1125 Bloor St. E Unit 5-6
Mississauga, ON L4Y 2N6
Phone: 905-361-1448
Fax: 905-785-8360

@ Mississauga Medical Arts
5010 Glen Erin Drive (inside Loblaw)
Mississauga, ON L5M 6J3
Phone: 905-288-5900
Fax: 289-726-2525

@ Pearl Medical Clinic
3176 Ridgeway Dr. Unit# 58
Mississauga, ON L5L 5S6
Phone: 647-948-8432
Fax: 1 855 647 1324

**** PLEASE COMPLETE THE FULL REFERRAL, INCLUDE THE MOST UP TO DATE CONTACT INFORMATION, COPY OF THE PATIENT'S UPDATED MEDICATIONS AND MEDICAL HISTORY. ALL INCOMPLETE REFERRALS WILL BE SENT BACK. ****

**** WE WILL ASSESS PATIENTS WHO ARE 6 MONTHS OF AGE AND OLDER! ****

REFERRING FOR: Assessment only Assessment + possible Paxlovid (you must consult your patient prior to referring and follow up with the patient 24 hours after starting Paxlovid)

NAME: _____
DOB: _____ AGE: _____
PREFERRED CONTACT#: _____
HEALTH CARD#: _____
FAMILY PHYSICIAN: _____

PLACE PATIENT LABEL HERE WITH MOST UP TO DATE INFORMATION

1) Please check all symptoms that apply (Must be less than 7 days to be seen at the clinic):

- Fever 37.8 and up Shortness of breath (New/worsening) Cough Nausea/Vomiting/Diarrhea/Abd. pain
 Fatigue, lethargy, malaise Sore throat/pain Change or loss of smell/taste Decreased/lack of appetite

Exact day onset of symptoms: _____ Date of COVID positive result: _____ RAT PCR

2) COVID-19 Vaccine Status:

- One dose Two doses 3+ doses Unvaccinated

3) To determine if your patient is eligible for paxlovid please complete the link below:

<https://docs.google.com/forms/d/e/1FAIpQLScwS00IHJHWb8XlGigpVvBvReC-UPhvHK89dhEKROJnmIMFvQ/viewform>
available at [COVID Treatment Info - mississaugamedicalarts.ca](https://www.mississaugamedicalarts.ca/COVID-Treatment-Info)

Is patient immunocompromised? Yes No

Patient informed about Paxlovid and interested/eligible Patient declined Paxlovid Not applicable

eGfr: _____ Date of eGfr: _____ (must be under 6 months)

ADDITIONAL COMMENTS:

PROVIDER'S FULL NAME: _____ Billing #: _____

OFFICE PHONE: _____ BACKLINE or CELL PHONE: _____

FAX NUMBER: _____ CLINIC ADDRESS: _____

