Townline Guardian Pharmacy
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Paxlovid Assessment Intake Form

Section 1. Personal Information		
First Name:	Last Name:	Age:
Ontario Health Card #:	Date of Birth (dd/mm/yyyy):	
Address:	Phone #:	

Section 2. General Screening Questionnaire	
1. Do you have a **valid prescription for Paxlovid™** from your physician? *If not, you need to obtain a prescription first from your physician.*	☐ Yes ☐ No
2. Are you **18 years of age** or older? *If not, you are not eligible for publicly-funded Paxlovid™.*	☐ Yes ☐ No
3. Did you receive a **positive** Covid-19 test result (including PCR or rapid antigen test self-administered at home or by another healthcare professional)? *If not, you are not eligible for publicly-funded Paxlovid™.*	☐ Yes ☐ No
4. Which **date** did you receive your positive result?	Date:
5. Which **date** did your **Covid-19 symptoms** started? *If you have no symptoms, you are not eligible for publicly-funded Paxlovid™.*	Date:
6. Will you be starting Paxlovid™ treatment within **5 days of symptoms onset**? *If not, you are not eligible for publicly-funded Paxlovid™.*	☐ Yes ☐ No

Section 3. Personal Medical and Medication History (Please fill this out if you are **NOT** an existing patient of our pharmacy)		
Medication & Strength (ie. Lipitor 10mg tablet)	**Direction of Use** (ie. take 1 tablet once daily)	**What is the medication used for?** (ie. high cholesterol)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
1. Do you have any **allergies** to any food or medications? If yes, please list all your allergies.		List:
2. Do you take any **non-prescription medications** or **supplements**? If yes, please list everything you are taking.		List:
3. Do you have any **renal impairment**? (ie. reduced kidney function)		☐ Yes ☐ No
4. Do you have any **hepatic impairment**? (ie. reduced liver function)		☐ Yes ☐ No

By signing below,

- I acknowledge that my medical & medication history that I have provided is accurate, complete and up to date.
- I agree that **I will NOT receive Paxlovid™** if I am not eligible *-OR-* if **our pharmacist considers Paxlovid™ is unsafe for me** due to potential serious drug-drug interactions or based on any other clinical judgement **even if I have a valid prescription**. I will seek alternative treatment options with my prescriber instead.

Patient Name (Print)	**Patient Signature**	**Date**