



For Respiratory Infection in Infants approved for Palivizumab and admitted for Respiratory Illness up to April 30, 2020

Name of Patient: _____ DoB: _____

Provincial Reference #: _____ PHN: _____

Admitting Hospital: _____ Attending Physician: _____

Admitted (dd/mmm/yyyy): _____ Discharged (dd/mmm/yyyy): _____

If Transferred:

Name of Hospital: _____ Attending Physician: _____

Admitted (dd/mmm/yyyy): _____ Discharged (dd/mmm/yyyy): _____

Reason(s) for Hospitalization (e.g., apnea, respiratory distress): _____

Final RSV test result: Negative Positive Unknown

Other significant viruses/bacteria isolated: _____

Medical support while in hospital

Supplemental O2: No Yes: Number of days: _____

NG feeding: No Yes: Number of days: _____

IV fluids: No Yes: Number of days: _____

PICU admission: No Yes: Number of days: _____

CPAP: No Yes: Number of days: _____

Intubated/Ventilated: No Yes: Number of days: _____

Other treatments? Please specify: _____

Please complete as much information as possible, then fax to 604-875-2879, or toll-free 1-877-625-7555.