Covid Treatment Plan

This information can help you to get the care you need if you get COVID-19. Show this information to healthcare workers so they can help you to rapidly get the right testing and treatment for you.

Date: (insert date)

Clinic Name (insert name and contact details)

Usual GP (insert name)

This Covid treatment plan/Care Plan is for	(Demographic details)
Goal of this plan	Early treatment of Covid-19 with oral antivirals to prevent serious illness
I have the following medical conditions:	
(insert all medical conditions)	
My medications are:	
(insert all medications)	
How many Covid Vaccines have I had?	□1 □ 2 □ 3 □ 4 □ 5

I have a RAT test at home and know to test early and when to get a PCR	
I know to phone early for a covid treatment appointment with my GP	
I have discussed with my doctor and (am/am not) eligible for GP prescribed oral anti covid mediation	If eligible under what criteria? (delete those that do not apply) aged 70+ aged 50+ with 2 risk factors or aged 18+ and immunocompromised or aged 30+, identify as Aboriginal or Torres Strait Islander origin with 2 risk factors
If not eligible I can access treatment via	N/A or add as appropriate
My eGFR is:	(Result) on (date)
The medication suitable for me is	Paxlovid/Molnupuravir
The Pharmacy where I can fill my prescription is:	
The adjustments I have to make while taking my medication are:	

IF YOU HAVE SEVERE SYMPTOMS CALL TRIPLE ZERO (000) IMMEDIATELY TO GET HELP

Severe symptoms might include severe shortness of breath or difficulty breathing, chest pain, lips or face turning blue, fainting, confusion or severe drowsiness.

Copy of Plan offered to patient? Yes true No false

Copy / relevant parts of the Plan supplied to other providers? Yes true No false

Plan added to the patient's records? Yes true No false

Date service was completed: (insert date)	**Proposed Review Date:**

I have explained the steps and costs involved, and the patient has agreed to proceed with the service.

GP's Signature: ____ Date: