Ontario

Collection, Use, and Disclosure of Personal Health Information Related to Evusheld Consent and Reporting Template for Youth and Adults

SECTION ONE: Patient information			
Last Name	First Name	Middle Name	Health Card Number
Street Address	City	Province	Postal Code
Home Phone	Mobile Phone	Email	
Sex		Age (years)	Date of Birth (DD/MM/YYYY)
☐ Male ☐ Female ☐ Prefer not to answer			

SECTION TWO: Consent for Collection, Use and Disclosure of Personal Health Information

I consent for _____ to collect and use my personal health
Insert Name of Primary Care Provider

information on this form and to disclose it to the local public health unit to be submitted into COVaxON so that a clinical record can be created for me for health care purposes and other purposes related to the administration of Evusheld.

☐ I consent to data collection by the _____ and the local
Insert Name of Primary Care Provider

public health unit, and disclosure of the data to health care providers for treatment purposes.

The personal health information is being collected for the purpose of providing care to you and creating a clinical record for you, and because it supports the Government of Ontario's ability to plan for and prevent the spread of COVID-19. Your personal health information on this form will be stored in a health record system under the custody and control of the Ministry of Health. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- It will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*.
- It may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you. I understand that I may withdraw this consent at any time by emailing vaccine@ontario.ca.

SECTION THREE: Consent for Communication and Research

You may be contacted by the local public health units or the Ministry of Health if they wish to communicate with you for purposes related to Evusheld administration and for the prevention of COVID-19 (for example, communications to remind you of scheduled appointments with your healthcare provider). If you consent to receiving these follow-up communications, please indicate this using the box below:

☐ I consent to receiving follow-up communications:

☐ by SMS/text: _____ ☐ by email: _____

You also have the option of consenting to be contacted about participation in COVID-19 related research studies/surveys. If you consent to be contacted, personal health information may be used to determine which studies may be relevant to you and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive Evusheld.

☐ I consent to be contacted about COVID-19 related research studies:

☐ by SMS/text: _____ ☐ by Phone: _____

☐ by email: _____

☐ by mail:

_____

I understand that I may withdraw this consent to be contacted for follow-up communications or research studies at any time by emailing vaccine@ontario.ca.

Printed Name	Signature	Date of Signature (DD/MM/YYYY)

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ If signing for someone other than myself, I confirm that I have the legal authority to provide consent for the individual that is to receive Evusheld

SECTION FOUR: ADMINISTRATION REPORTING (FOR CLINICIAN TO COMPLETE)			
Health Care Practitioner name	Email:	Phone (office,ext):	Fax (office):
Health Care Practitioner address:	City	Province	Postal code

Health Care Practitioner prescribing information
Medication(s) In order of administration: Dose / Route / Frequency / Duration (Medication(s) will be administered according to established evidence informed practices and protocols) Prescriber please select one of the following instructions and confirming dosing and repeats if applicable.
☐ **EVUSHELD 300mg (DIN 02526271):** • cilgavimab 100mg/mL injection: 150mg by IM injection Once and tixagevimab 100mg/mL injection: 150mg by IM injection Once
☐ **EVUSHELD 600mg (DIN 02526271):** • cilgavimab 100mg/mL injection: 300 mg by IM injection Once and tixagevimab 100mg/mL injection: 300 mg by IM injection Once

Anatomical site of administration	Date of administration (DD/MM/YYYY)	Time of administration
Product lot #:	Product expiry date (DD/MM/YYYY)	Unit of measure (mL)