WRITTEN PATIENT CONSENT FORM
USE OF SOTROVIMAB IN ADULTS WITH COVID-19

Sotrovimab (Xevudy®) is a provisionally registered for use in Australia for the treatment of mild to moderate COVID-19. Australia's National COVID-19 Clinical Evidence Taskforce has made recommendations about when sotrovimab is most likely to work in the treatment of COVID-19.

PATIENT CONSENT

By signing this form, I _____ understand that:

(write name of patient / person responsible)

- sotrovimab (Xevudy®) is provisionally registered for use in Australia for the treatment of some cases of mild to moderate COVID-19 and more information about its effectiveness and safety is needed before it is fully registered;
- there are no guarantees of the effectiveness of sotrovimab when it is used to treat COVID-19 and I/the person I am responsible for may not experience any benefit;
- there are no guarantees of the safety of sotrovimab when it is used to treat COVID-19 and even with careful precautions in place, unforeseen complications may occur;
- there is potential for medicine interactions (known and unknown) with the use of sotrovimab; sotrovimab may reduce your response to vaccines soon before or after they are administered; (please ask your doctor about future vaccinations once you have recovered from COVID-19); and,
- there is a possibility of experiencing side effects (known and unknown) with the use of sotrovimab.

I confirm that I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I can change my mind and withdraw my consent to being treated with sotrovimab at any time.
With this knowledge, I **consent** to the use of sotrovimab in the treatment of me/the person I am responsible for.

Patient's name: _____ **MRN:** _____ **Age:** _____

Signature of patient (or person responsible*): _____ **Date:** ____/____/____

If applicable, name & signature of witness: _____ **Date:** ____/____/____

Witness is not to be a member of the treating team. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

I agree to be contacted in the future about how I (or the person I am responsible for) am (are) doing and how I (they) felt after receiving sotrovimab:

◯ Yes / ◯ No If yes, please provide your phone number: _____

*If the person responsible has signed, please provide details below:

Name: _____ **Date of Birth:** ____/____/____

Address: _____ **Contact Number:** _____

Relationship to patient: _____ **Reason for representation:** _____

DOCTOR'S DECLARATION

☐ I have provided to the patient/their person responsible an explanation of the use of sotrovimab, its potential benefits and harms and the relevant **Patient Information Leaflet**. I believe the information has been understood.

Please print & sign this form and file with the patients' Health Record. Further information about consent found here.

Doctors name & designation: _____

Signature: _____ **Date:** ____/____/____

If the patient cannot converse adequately in English, please use an accredited Health Care interpreter. Do not rely on relatives or other parties for interpreting.

Language: _____ **Name of interpreter & ID #:** _____

Signature: _____ **Date:** ____/____/____

Completed signed form should be kept in the patient's Health Record.