**Bamlanivimab Consent Form (SAMPLE)**

Your physician has ordered a medicine called bamlanivimab for the treatment of coronavirus disease 2019 (COVID19). Bamlanivimab is an investigational medicine used for the treatment of COVID-19 in non-hospitalized adults with mild to moderate symptoms and who are at high risk for developing severe COVID-19 symptoms or the need for hospitalization.

The FDA has authorized the emergency use of bamlanivimab for the treatment of COVID-19 under an Emergency Use Authorization (EUA). Receiving bamlanivimab may benefit certain people with COVID-19.

Bamlanivimab is given to you through a vein (intravenous or IV) for at least 1 hour. You will receive one dose of bamlanivimab by IV infusion.

Possible side effects of bamlanivimab are:

* Allergic reactions: fever, chills, nausea, headache, shortness of breath, low blood pressure, wheezing, swelling of your lips, face, or throat, rash including hives, itching, muscle aches, and dizziness.
* The side effects of getting any medicine by vein may include brief pain, bleeding, bruising of the skin, soreness, swelling, and possible infection at the infusion site.
* These are not all the possible side effects of bamlanivimab

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(or legal guardian/representative) have been informed about the potential benefits and risks of Bamlanivimab and have received *the* ***Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) of Bamlanivimab for Coronavirus Disease 2019 (COVID-19).***

Select one of the following (place an X in the box that you agree with)

* Consent or agree to use bamlanivimab infusion
* Decline use of bamlanivimab.

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 *Date Resident Signature*

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 *Date Signature/Title – Witness*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the responsible party for
who is my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and a resident of this facility, hereby give my permission for the facility to administer bamlanivimab infusion.

*Relationship*

*Representative*

*Name of Resident*

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 *Date Representative Signature*