**Referral Form POST (LONG) COVID Service**

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| Date of referral:<Today's date> |  |
| Primary Care referral ☒ Yes  | Secondary Care referral ☐ Yes  |
| Referrer name:<Your Name>Organisation: <Organisation Details>Team Contact No: <Organisation Details> Email: <Organisation Details> |
| Usual GP: <GP Name><GP Name>GP Organisation: <Organisation Details>Team Contact No: <Organisation Details> Email:<Organisation Details> |
| Patient information |
| NHS No <NHS number> |  |
| Surname: <Patient Name> | First Name: <Patient Name> |
| Title: <Patient Name> | Gender: <Gender> | D.O.B: <Date of Birth> |
| Address: <Patient Address> | Tel: <Patient Contact Details> |
| Mobile: <Patient Contact Details> |
| Email: <Patient Contact Details> |
| Ethnicity: <Ethnicity> | Language spoken: <Main spoken language> |
| Interpreter Required: ☐ Yes ☐ No |
| Patient (or relevant guardian if patient lacks consent) gives consent for referral? ☐ Yes ☐ No |

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|  **Clinic Acceptance Criteria:** |
| **People aged 16 and over:****Section 1 - WITH** a convincing history and likely diagnosis of an **acute COVID illness** that doesn’t predate the COVID pandemic (evidence of a positive COVID test is NOT a requirement).**Section 2 - AND** the patient has been suffering with symptoms **lasting over 12 weeks** following an acute COVID illness **OR** a clear reason is stated in the referral letter why a review is thought to be required before 12 weeks (please note that the POST COVID syndrome service is **NOT** appropriate for patients who require urgent referrals).**Section 3 - AND** these symptoms have a significant impact on physical recovery, psychological wellbeing, or ability to perform usual activities.**Section 4 - AND other physical causes of these symptoms** **have been excluded** by physical examination and appropriate investigations**.** **Please note that patients whose symptoms predate the pandemic and have not changed as a result of a COVID infection are NOT appropriate for this service.****Referrals which do not meet the referral criteria will be returned** |
| **Reason for Referral:**  |
| **Section 1. Convincing history and likely diagnoses of an acute COVID illness that doesn’t predate the COVID pandemic**What are clinical indications for suspecting the patient has had COVID-19?       |
| **Section 2. Duration:** Please provide approximate date of first significant Covid-19 symptoms:Over 12 weeks: ☐ Yes ☐ NoWas patient hospitalised with COVID symptoms? If so, what were the dates of hospital admission? Please attach any relevant hospital letters.☐ N/A  |

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| DD | MM | YY |
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From:

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To:

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| Reason why a review is thought to be required before 12 weeks (please note that the POST COVID syndrome service is **NOT** appropriate for patients who require urgent referrals). ☐ N/A       |
| **Section 3. Persistent Symptoms:**

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| **Symptom/s** | **Present** |
| Fatigue | ☐Yes ☐No  |
| Shortness of breath | ☐Yes ☐No  |
| Palpitations | ☐Yes ☐No  |
| Persistent coughing | ☐Yes ☐No  |
| Headaches | ☐Yes ☐No  |
| Muscle/joint pain | ☐Yes ☐No  |
| Cognitive signs | ☐Yes ☐No  |
| Other (please state): |  |

**AND** these symptoms have a significant impact on physical recovery, psychological wellbeing, or ability to perform usual activities ☐Yes ☐No  |
| Please give details of the patient’s current symptoms?      |
| **Section 4. Examination Findings & Investigation Results:****EXAMINATION FINDINGS**All referrals MUST have the following details attached. Referrals without this information will be returned:

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|  | **Relevant examination findings** |
| Chest Examination |       |
| Blood Pressure | <Latest BP> |
| Heart Rate | <Numerics> |
| Oxygen Saturations |       |
| Urine Dipstick |       |
| Other |       |

**INVESTIGATION RESULTS**All referrals MUST have the following results attached. Referrals without this information will be returned:

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|  | **Results attached** |
| FBC | ☐Yes ☐No       |
| U&E | ☐Yes ☐No       |
| LFT | ☐Yes ☐No       |
| TFT | ☐Yes ☐No       |
| CRP | ☐Yes ☐No       |
| Coeliac screen (Endomysial abs or tTG) | ☐Yes ☐No       |
| Creatine Kinase (CK) | ☐Yes ☐No       |

<Long COVID bloods (view)>If a patient has any of the symptoms below, then the results of the investigations listed for that specific symptom MUST be attached. Referrals without this information will be returned:* Shortness of Breath

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|  | **Results attached** |
| BNP | ☐Yes ☐No       |
| CXR\* | ☐Yes ☐No       |

\* Due to the long waits for routine CXRs in some areas, it is recommended that an **urgent CXR** is requested for this indication.* Palpitations

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|  | **Results attached** |
| ECG | ☐Yes ☐No       |

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