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

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| Date of referral: |  |
| Primary Care referral [ ]  Yes  | Secondary Care referral [ ]  Yes  |
| Referrer name:Organisation: Team Contact No: Email:  |
| Usual GP: GP Organisation: Team Contact No: Email: |
| Patient information |
| NHS No |  |
| Surname:  | First Name:  |
| Title:  | Gender:  | D.O.B:  |
| Address: Postcode:  | Tel:  |
| Mobile:  |
| Email:  |
| Ethnicity:  | Language spoken: |
| 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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| DD | MM | YY |
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To:

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| DD | MM | YY |
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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 |       |
| Heart Rate |       |
| 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       |

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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