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

|  |  |  |
| --- | --- | --- |
| 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 | | |

|  |  |
| --- | --- |
| **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  No  Was patient hospitalised with COVID symptoms? If so, what were the dates of hospital admission? Please attach any relevant hospital letters.  N/A | |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  |   From:   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  |   To:   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| 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:**   |  |  | | --- | --- | | **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:   |  |  | | --- | --- | |  | **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:   |  |  | | --- | --- | |  | **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  |  |  | | --- | --- | |  | **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  |  |  | | --- | --- | |  | **Results attached** | | ECG | Yes No | | |