**This referral is only for patients who have suspected Long Covid symptoms**

**Email this referral form to:**

**Southern Health FT –** shft.respiratory-assessment@nhs.net

**Telephone – 0330-303-1790**

**The referral to the Long Covid service is for people with persistent troublesome symptoms lasting more than 12 weeks following the initial acute illness with suspected Post-COVID-19 syndrome.**

The patient will initially be assessed by an AHP as part of a multi-disciplinary team, and then directed into appropriate specialist services, or signposted into non-health services should these needs apply.

For able patients they will be also be supported to enrol in an APP.based program.

**It is imperative that the referring clinician is satisfied that alternative diagnoses that would account for the patients symptoms have been excluded before referral. This applies to pre-referral testing or indeed direct referral on to secondary care clinics in the first instance.**

*For example:**if a patient is still significantly short of breath at 12 weeks and you have reviewed bloods, ECG, Chest x-ray, if the CXR is abnormal (underlying pneumonia), or if the CXR is normal and you are concerned re: lung function, ECHO, CT please refer to Respiratory*

**Such a referral to secondary care does NOT preclude referral to the Long-Covid service, if indicated refer to both Respiratory & the Long Covid service.**

The selected consultations, medication, known drug allergies, investigations and examination will be auto populated into the clinical referral letter

**Mandatory requirements**

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| **Patients Name:** |
| **NHS Number:** | **Practice Name:****Registered GP Name:****Surgery address:****Tel. no:** |
| **Address:****Post Code:****Tel no. Home:** **Work: Mobile No:****Email address:****Pre Covid Employment status:****Post Covid Employment status:****Has the patient been able to return to work?** [ ] **Yes** [ ]  **No**  |
| **Date of birth: Gender Identity: Ethnicity:** |
| **Date of referral:****Date of diagnosis or symptom onset:** | **Referred by:** GP [ ] AHP [ ]  Other [ ]  | **Referring persons name:** |
| **Next of Kin:** | **Has Patient consented to referral:**[ ] Yes [ ]  No | **Has the patient opted out of the national data sharing agreement**[ ] Yes [ ]  No |
| **The patient has:** | [ ]  Tested positive for COVID-19 |
| [ ]  Suspected COVID-19 (suspected COVID-19 prior to testing being available) |
| **Has the patient been seen in person to complete a comprehensive physical assessment?** |  [ ] Yes - who has completed this assessment? **All patients must have been seen face to face for a full physical assessment, if not completed, the referal into the clinic will be declined** |
| **Cardiovacsular obs taken**  | [ ] Yes [ ]  NoResult:  |
| **Lying and Standing BP completed if symptomatic**  | [ ] Yes [ ]  NoResults:  |
| **Symptoms**Select **new** symptoms patient has experienced since the onset of the virus | [ ]  **Respiratory symptoms** (SOB) (*please specify below if the patient has been refered to Respiratory for* *suspected or diagnosed underlying pneumonia* [*https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/*](https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/)*\*if pt still breathless at 12 weeks request a Chest X-ray***Cardiovascular symptoms** [ ]  Chest tightness [ ]  Chest pain [ ]  Palpitations**Generalised symptoms** [ ]  Fatigue [ ]  Fever [ ]  Joint and Muscle Pain [ ]  Skin rashes**Neurological symptoms**  [ ]  Cognitive impairment [ ]  Headache [ ]  Sleep disturbance [ ]  Peripheral neuropathy (pins and needles/numbness) [ ]  Dizziness**Psychological symptoms** [ ]  Deprsssion /anxiety [ ]  Problem sleeping [ ]  Delirium in older persons **Gastrointestinal symptoms**  [ ]  Abdominal pain [ ]  Nausea [ ]  Diarrhoea [ ]  Anorexia [ ]  Reduced appetite**Ear, nose and throat symptoms**  [ ]  Tinnitus [ ]  Earache [ ]  Sore throat [ ]  Dizziness [ ]  Loss of taste and/or smell |
| Provide details of other symptoms | Other (provide details below) |
| **History**Has the patient had a COVID related admission to hospital?Were they admitted to ICU/HDU/RespHC/Covid pneumonia? | [ ] Yes [ ]  No[ ] Yes [ ]  No Please attach relevant documentation e.g.discharge summaries and follow up plans: |
| **Is the patient using home oxygen?**  | [ ] Yes [ ]  No |
| **Other relevant medical history including allergies:** |  Please attach relevant medical history |
| **Consider following Investigations, these tests are not obligatory:**Bloods tests:ECG - actioned if abnormal(if appropriate)Chest X-ray – actioned if abnormal | Please consider the following if clinically indicated: |
| Full blood count Liver & Renal function Troponin HbA1C Thyroid TFT C-reactive protein Creatinine Kinase D-dimer Brain Natriuretic peptides Ferritin *(to assess inflamation and prothrombotic states)*  |
| [ ] Yes [ ]  No [ ] Yes [ ]  No |
| **Has the patient been referred to any other community services or acute post Covid clinics?** | ☐ Occupational therapy  ☐ ITalk / Talking change (IAPT)☐ Social prescribing / Health connectors / Wellbeing Coaches☐ Respiratory Medical review ☐ Pulmonary Rehab☐ Musculoskeletal team (Physiotherapy)☐ Neurology ☐ Neurology Rehab ☐ Cardiology  ☐ Post Covid secondary care, follow-up clinic (post ICU admission) ☐ Other – please specify |
| **Has the patient been advised to access the yourCovidrecovery website:** | [ ] Yes [ ]  No  **https://www.yourcovidrecovery.nhs.uk/** |

BMJ post covid guidance <https://www.bmj.com/content/370/bmj.m3026/infographic>

The Long Covid referral form to be reviewed regularly to ensure its aligned to NICE guidance