**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](mailto: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  No  Result: | |
| **Lying and Standing BP completed if symptomatic** | Yes  No  Results: | |
| **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