**LONG COVID Service - This referral is only for patients who have suspected Long Covid symptoms**

**To refer email this form to: Southern Health FT –** [shft.swlongcovid@nhs.net](mailto:shft.swlongcovid@nhs.net)

**Telephone – 0300 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 be assessed by an AHP as part of a virtual rehabilitation service, and their recovery supported by the ‘living with Covid app’ (any patient who cannot access digital rehab will be offered the service face to face or via the phone). The AHP will attend weekly Long Covid MDT meetings, with Respiratory Consultant and Psychological therapists working collaboratively to support the rehabilitation needs of the patient.

The **referring clinician** needs to be satisfied that alternative diagnoses have been explored/excluded before referral. If you are unsure, you can contact your local service for advice and guidance or to book a slot on the long Covid MDT meeting to discuss your patient.

* **P**lease consider advising the patient to use the www.yourcovidrecovery.nhs.uk [Your COVID Recovery | Supporting your recovery after COVID-19](https://www.yourcovidrecovery.nhs.uk/)
* BMJ reference poster: Post Covid guidance for clinicians <https://www.bmj.com/content/370/bmj.m3026/infographic>

*If indicated you can refer to parallel services, for example: Respiratory &* ***this*** *Long Covid service.*

**This referral is not an acute pathway.**

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| **Patient’s Name:** | | | | | |
| **NHS Number:** | | | | | **Practice Name:**  **Registered GP Name:**  **Surgery address:**  **Tel. no:** |
| **Address:**  **Post Code:**  **Tel no. Home:**  **Work: Mobile No:**  **Email address:**  **Has the patient been able to return to work? Yes  No  N/A** | | | | |
| **Date of birth: Gender Identity: Ethnicity:**  **Do you need an interpreter? Yes  No** | | | | | |
| **Date of referral:**  **Date of diagnosis or symptom onset:** | | | | | **Referring person’s name and job title:** |
| **Next of Kin, if known:** | **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 (must be over 12 weeks) | | | | |
| Had suspected COVID-19 (must be over 12 weeks) | | | | |
| **History**  Has the patient had a COVID related admission to hospital?  Were they admitted to ICU/HDU/RespHC/Covid pneumonia? | Please attach relevant documentation if you have them e.g.discharge summaries and follow up plans if available, or the name of hospital  Yes  No  Yes  No | | | | |
| **Has the patient been seen in person to complete a physical assessment appropriate to their symptoms?** | Yes and my working diagnosis is that this is Long COVID  **All patients must have been seen face to face for an appropriate assessment if not completed, the referral into the clinic will be declined. If you wish you can share any relevant findings at the end of the form in ‘other useful clinical information’** | | | | |
| **Cardiovascular obs taken (blood pressure/heart rate)** | Yes  No  Result: | | | | |
| **Lying and Standing BP complete if postural symptoms** | Yes  No  Result: | | | | |
| **Symptoms**  Select **new** symptoms the patient is currently experiencing since their COVID infection | **Respiratory symptoms** (SOB) has the person had an xray with diagnostic changes?  NICE guidance suggests if pt SOB at 12 weeks to request a Chest Xray if they have not had one.  **Cardiovascular symptoms**  Chest tightness  Chest pain  Palpitations  **Generalised symptoms**  Fatigue  Fever  Joint and Muscle Pain  Skin rashes  **Neurological symptoms**  Cognitive impairment ‘brain fog’  Headache  Peripheral neuropathy (pins and needles/numbness)  Dizziness  **Psychological symptoms**  Depression /anxiety  Problems sleeping  Delirium in older persons  **Gastrointestinal symptoms**  Abdominal pain  Nausea  Diarrhoea  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) | | | | |
| **Consider the following Investigations if clinically indicated,** these tests are not obligatory:  **Bloods tests:** | Full blood count,  Ferritin (to assess for inflammation or prothrombotic state),  Liver & Renal function  HbA1C  Thyroid TFT  C-reactive protein  Creatinine Kinase  Brain Natriuretic peptides  Vit-D  Relevant information: | | | | |
| **ECG** | Yes  No |  | | | |
| [sit to stand test](https://t.co/26qOlCoHKR)(written guidance on S1/EMIS) | Yes  No |
| **Chest X-ray** | Yes  No |
| **Has the patient been referred to any other community services or acute post Covid clinics?** | ☐ Occupational Therapy    ☐ ITalk / Talking Change (IAPT) *can be done in addition to this referral if indicated*  ☐ Social Prescribing / Health Connector / Wellbeing Coach  ☐ Respiratory  ☐ Pulmonary Rehabilitation  ☐ Musculoskeletal Physiotherapy  ☐ Neurology | | | ☐ Neurology Rehab    ☐ Cardiology    ☐ Post Covid secondary care, follow-up clinic (post ICU admission)  ☐ Other – please specify | |
| **Other useful clinical information you would like to share**:  Please provide the patient with the Long Covid leaflet | | | | | |
| **PMH** | | | **Medication history** | | |