

**Suspected Post COVID-19 Local Paediatrician Referral Form for GPs**

Post COVID (also known as Long COVID) is a novel condition with limited evidence regarding its presentation in Children and Young People (CYP).

Please note if urgent assessment of specific symptoms e.g. severe headaches with red flags/ abnormal blood tests suggesting another condition/ respiratory symptoms with low saturations then refer to local secondary care paediatrician

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| --- | --- | --- | --- | --- |
| **Patient Information** | | | | |
| **Patient Details** | | | | |
| **First name** |  | | | |
| **Surname** |  | | | |
| **D.O.B** |  | | | |
| **NHS number** |  | | | |
| **Gender/Transgender identifier** |  | | | |
| **Patient Address (postcode)** |  | | | |
| **E-Mail address** |  | | | |
| **Ethnicity** |  | | | |
| **Preferred choice of communication** |  | | | |
| **Would virtual MDT review be accessible.** |  | | | |
| **School details (including Home School information)** |  | | | |
| **Next of Kin Name and Contact Details** |  | | | |
| **Additional Supporting Information** | | | | |
| **Height** |  | | | |
| **Weight** |  | | | |
| **BMI** |  | | | |
| **Patient Clinical Details** | | | | |
| **Allergies** |  | | | |
| **Current Medication** |  | | | |
| **Is the patient under the care of any other services?** |  | | | |
| **Is there or has there been a safeguarding alert for this patient?** |  | | | |
| **Co-morbidities** | | | | |
| **Physical co-morbidities:** |  | | | |
| **Neurodevelopmental condition(s):** |  | | | |
| **Mental health condition(s) e.g. depression, anxiety, personality disorder:** |  | | | |
| **Health professionals currently/previously involved in patients care.** |  | | | |
| **Clinical Overview** | | | | |
| **History of suspected Covid-19 infection with one of the three criteria below:** | | | | |
| 1. **Previous PCR positive for SARS-CoV-2**   **Date?** | | Y/N | | |
| 1. **COVID antibody positivity**   **Date** | | Y/N | | |
| 1. **Clear close epidemiological link to be determined on a case by case basis (school/family etc)**   **Date** | | Y/N | | |
| **Date of previous positive COVID-19 swab (if performed)** | |  | | |
| **Does the individual have one or more of the following as a predominant symptom? Please detail.** | | | | |
| (i) Severe fatigue that is preventing ADLs – e.g. going to school /activities/nursery/ play dates/ regression | | |  | |
| (ii) Change from baseline that is unacceptable to referring Dr/Pt | | |  | |
| (iii) Temporally associated persistent unexplained physical symptoms | | |  | |
| **History** (including potential fluctuating symptoms and trends)  Please rate on scale 0-10 ( 0= no symptoms 10 = severe) | | | | |
| **Symptom** | **Score 0-10** | | | |
| **Fatigue** |  | | | |
| **Abdominal pain** |  | | | |
| **Anxiety / low mood** |  | | | |
| **Sleep** |  | | | |
| **Pain** |  | | | |
| **Respiratory** |  | | | |
| **Brain fog** |  | | | |
| **Headache** |  | | | |
|  | | | | |
| **How many days of school /education has the individual missed in the last 2 weeks? (Write N/A if holidays)** | | | | |
| Does the individual have a history of PIMS-TS? | | **Y/N** | | **If Yes refer to secondary care team** |
| **Patient baseline** (Gain an understanding of the patient’s functional baseline prior to contracting COVID-19) | | | | |
| **Examination findings** | | | | |
| **Bedside Tests *(required)*** | | | | |
| **Test** | **Result** | | | |
| **Heart rate (resting level)** |  | | | |
| **Oxygen saturations (resting level)** |  | | | |
| **Temperature** |  | | | |
| **Blood pressure** |  | | | |
| **Result of sit/stand assessment** |  | | | |
| **Blood sugar.** |  | | | |
| **Blood Tests *(required)*** | | | | |
| **Test** | **Result** | | | |
| **Full blood count** |  | | | |
| **Blood Film** |  | | | |
| **CRP** |  | | | |
| **Blood Glucose** |  | | | |
| **Urea and electrolytes** |  | | | |
| **LFT** |  | | | |
| **TFT** |  | | | |
| **ESR** |  | | | |
| **Coeliac Screen** |  | | | |
| **CK** |  | | | |
| **Ferritin** |  | | | |
| **Vitamin D** |  | | | |
| **Vitamin B12** |  | | | |
| **Other** |  | | | |
| **Other Tests (performed within the last 4 weeks)** | | | | |
| **Test** | **Result** | | | |
| **If GI symptoms a faecal calprotectin must be sent Y/N** |  | | | |
| *MRI Brain/CXR* |  | | | |
| **Social Assessment** | | | | |
| **Impact of condition on family and education** |  | | | |
| **Individual goals and aspirations** |  | | | |
| **How do you think the patient will benefit from the referral?** |  | | | |
| **Referral Information** | | | | |
| **Date of Referral** |  | | | |
| **Referral Source/Involvement of other providers including CAMHS, education providers, community teams)** |  | | | |
| **Name of referrer** |  | | | |

**Send referral to** [**SNHS.Solentchildrenstherapyservice@nhs.net**](mailto:SNHS.Solentchildrenstherapyservice@nhs.net)