|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | **Referrer Details** | |
| Surname: |  | Referring GP: |  |
| Forename: |  | Usual GP: |  |
| Address: |  | Address: |  |
| Home tel: |  | Tel: |  |
| Mobile tel: |  | Email: |  |
| Date of Birth: |  | Referral Date: |  |
| NHS Number: |  | **Interpreter Required:** | Yes |
| **Preferred Language\*:** | English |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Speciality\*:** | Respiratory | | **Clinic\*:** | Post Covid Syndrome |
| **Referral Status\*:** | Routine | Urgent | **Intended Place of Referral\*:** | ACUTEACUTE |

|  |  |  |
| --- | --- | --- |
| **POST COVID FATIGUE** | | |
| Appropriate assessment by primary care is required before referral. See GP Gateway for more details. Clinic acceptance criteria:   * Positive Covid-19 test at acute phase or antibodies * Relevant and sustained significant symptoms for **at least 12 weeks** * **X-ray** and **bloods** need to be completed in advance | | |
| **Reason for Referral (referral letter):**  Please attach any relevant tests, investigations or clinic letters. | | |
| **Section 1. Covid-19 Diagnosis**  **EITHER** Patient diagnosed at the acute stage via PCR or similar test:  If yes please indicate date of test: | | Yes  No   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **OR** Covid-19 Antibody test has proved positive:  If yes please indicate date of test:  **If Covid-19 diagnostic test/s has proven negative please do not refer to the Post-Covid Clinic. Consider A&G or routine referral.** | | Yes  No   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **Section 2. Duration:**  Please provide approximate date of first significant Covid-19 symptoms: | | |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **Section 3. Persistent Symptoms**   |  |  | | --- | --- | | **Symptom/s** | **Present** | | Fatigue | Yes No | | Shortness of breath | Yes No | | Persistent coughing | Yes No | | Headaches | Yes No | | Muscle/joint pain | Yes No | | Cognitive signs | Yes No | | Other (please state): |  | | | |
| **Referring clinician:**  \* Required  \* Required\* Consider if an IFR form is appropriate for this patient? Do not proceed with this application. | | |
| **Allergies:** | | |
|  | | |
| **Consultation Information:** | | |
|  | | |
| **Active Problem Information:** | | |
|  | | |
| **Current Medication:** | | |
|  | | |
| **Relevant Information** | | |
| **Alcohol:** | **BMI:** | |
|  |  | |
| **BP:** | **Smoking Status:** | |
|  |  | |
| **Patient Sex:** | **Gender:** | |
|  |  | |