|  |  |
| --- | --- |
| **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:** |
|  |  |