**APPENDIX A**

**Suspected Long Covid in Children and Young people**

**Referral form for Primary Care**

Post covid or Long Covid is a novel condition which has limited evidence regarding manifestation of symptoms in children and young people. Primary care physicians are encouraged to contact or refer to their local paediatrician to discuss cases with unclear diagnosis or request in person assessment. Access to the Virtual MDT is for patients believed to have post COVID syndrome via referral from secondary care paediatrician.

**This referral is for children and young people under 16 years of age.**

**For young people aged 16-18yrs discuss with the MDT assessment team or Adult Long Covid team based on young person’s preference**

**Exclusion criteria: Consider if the symptoms can be better explained by any known underlying physical and mental health issues. (Unless there has been a change in symptoms since contracting COVID-19)**

**Referrals should be sent to your local paediatric team via usual outpatient referral pathway.**

Kindly fill in the proforma with as much detail as possible.

***If your patient is unable to access virtual consultation (zoom, accurx, telephone) please tick here*** ☐

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| **Consent for referral** |
| Patient/Parent consent obtained for referral?  (Patient consent will include access to GP Care Records.) |
| If consent not obtained, please provide further details: |

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| **Patient details** |

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| --- | --- | --- | --- |
| First Name |  | Surname |  |
| D.O.B |  | NHS Number |  |
| Gender |  | Ethnicity |  |
| Address with postcode |  | Contact number/s | Can voicemail be left on the number? |
| Parent’s name |  | Who has parental responsibility? |  |
| Parent's address if different to above |  | Ethnicity |  |
| Language spoken  Interpreter required |  | Does patient use alternative or augmented communication? |  |
| Details of any safeguarding alert for the patient including contact number for relevant agencies |  | Details of any psychosocial concerns? |  |
| School |  | School Attendance | -----% |
| Allergies |  | Current medications |  |
| Details of Infection control risk? |  | Physical co-morbidities |  |
| Pre-existing mental health condition |  | Neurodevelopmental condition/s |  |
| Smoking status |  | Details of other professionals involved |  |

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| **Referrer details** | |
| Name |  |
| Role |  |
| Address |  |
| Email |  |
| Tel number |  |

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| --- | --- | --- | --- |
| **Covid infection details** | | | |
| Date of onset of symptoms |  | Symptoms reported |  |
| Duration of symptoms |  | Date of PCR with result |  |
| Covid antibody |  |  |  |
| Clear close epidemiological link present |  | Details of this contact |  |
| How was the covid infection managed? | Home☐ A/E ☐ Oxygen ☐ HDU ☐ PICU☐ Other ☐ | | |
| Details of PIMS TS if affected |  |  |  |
| **History of presenting complaints (Include trends/fluctuations if any; consider NICE definition** | | | |
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| **Details of management strategies tried thus far, for the above symptoms** |
| **By Patient** |
| **By Yourself** |

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| **Details of impact of above symptoms on activities of daily living (include details of difference between baseline and current levels)** |
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| **Relevant Past medical History** |
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| **Medication** |
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| **Birth and Immunisation History** |
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| **Family History, set up and support** |
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| **Family’s and/or CYP’s Expectations from the referral** |
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| --- | --- | --- | --- |
| **Details of investigations in previous 12 weeks** | | | |
| **TEST** | **DATE** | **LOCATION** | **RESULT (normal/ abnormal)** |
| FBC |  |  |  |
| UEs, Cr |  |  |  |
| Bone profile |  |  |  |
| LFTs |  |  |  |
| TSH |  |  |  |
| FT4 |  |  |  |
| *Coeliac screen* |  |  |  |
| CK |  |  |  |
| CRP |  |  |  |
| ESR |  |  |  |
| COVID Antibody (where appropriate) |  |  |  |
| ECG |  |  |  |
| CXR |  |  |  |
| Other |  |  |  |
| Imaging (where completed) |  |  |  |

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| **Other Information** (please include any other relevant information to support your referral |
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| **Other referral outcomes where previously undertaken** (*please include copies of any correspondence from specialist assessments*) |
| **Respiratory**  **Cardiology**  **Gastro**  **Other** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of local therapists involved** | | | |
| **Professional** | **Name** | **Base** | **Contact details** |
| OT |  |  |  |
| Physio |  |  |  |
| Psychologist |  |  |  |
| CAMHS |  |  |  |
| Dietitian |  |  |  |
| SLT |  |  |  |

***Please attach copies of all results- referrals without results attached will be rejected***

\*\* End of Appendix A\*\*