NHS
Rotherham
Clinical Commissioning Group

POST ACUTE COVID ("long covid")REHABILITATION REFERRAL FORM

DATE OF REFERRAL: Click here to enter a date.

Does the patient have mental capacity to agree to this referral? Y ☐ N ☐ This referral has been discussed with the patient and the patient consents to relevant information being shared with the service provider. Patient consent will include provider access to Summary Care Records. If consent not obtained, please provide further details:
Does clinician have consent to discuss with patient's relative Y ☐ N ☐.
If yes state relatives name and number(Next of Kin / Main Carer):

PATIENT DETAILS

Title: Click here to enter text.	Surname: Click here to enter text.	First Name: Click here to enter text.	
NHS No: Click here to enter text.	Date of Birth: Click here to enter a date.	Age: Click here to enter text.	Sex: Click here to enter text.
Home address: Click here to enter text.		Postcode: Click here to enter text.	
Preferred No ☐ Patient Home Contact No: Click here to enter text. Preferred No ☐ Patient Mobile Contact No: Click here to enter text.		Voicemails can be left? Y ☐ N ☐ Voicemails can be left? Y ☐ N ☐	
Ethnicity: Click here to enter text.	Language: Click here to enter text.	Interpreter Required? Y ☐ N ☐ Does the patient have hearing issues? Y ☐ N ☐	

Smoking Status: | Allergies:

Does the patient have a DNACPR? Y ☐ N ☐ If "Yes" is there a copy in the patient's home? Y ☐ N ☐

Covid Status

Suspected COVID ☐	Date:	Date of onset of symptoms:
Test(s) Positive ☐	Date	Duration of symptoms:
Negative ☐	Date:	

Brief description of initial symptoms:
Fever ☐ Cough ☐ Anosmia ☐ SOB ☐ Other-(please state):

Management-(Please send ALL relevant information on care)
☐ Home ☐ A&E ☐ Hospital admission ☐ITU ☐ Outpatient clinic

Investigation already completed (Please send results).
☐ Bloods ☐CXR ☐Echo ☐CT/CTPA ☐Other (please state):

The below are mandatory for referral acceptance.
SpO_2: BP: RR: HR:
Bloods – FBC, U&Es, LFTs, CRP, Haematinics, Calcium ☐ BNP ☐ (required if heart failure suspected)

REASON FOR REFERRAL - Please indicate reasons for referral.

☐ Ongoing Cough	☐ Swallowing issues	☐ Anxiety / PTSD
☐ Ongoing SOB	☐ Weight Problems	☐ Low Mood
☐ Ongoing Fatigue	☐ Mobility Issues	☐ Neurological Issues
☐ Chest Pain	☐ Memory/Cognitive	☐Pressure Ulcers/Skin issues
☐ Has IHD/PE been excluded	☐ Dizziness	

Please give a brief outline of the ongoing problems and what has been tried so far:

Were any of the symptoms above present prior to their COVID illness? Y ☐ N ☐

Is the patient under the care of any other services post COVID19? Y ☐ N ☐ (If yes please state):

Name of Referrer: Click here to enter text. Profession: Click here to enter text. Organisation/Practice Code: Click here to enter text. Contact No: Click here to enter text.	GP Practice: Click here to enter text. GP Practice Contact No: Click here to enter text. GP Alternative Contact No: Click here to enter text. GP Practice E-mail Address: Click here to enter text.
GP/Referrer Signature: Click here to enter text.	Date:Click here to enter a date.