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| **SNEE ICS Long Covid Assessment Service (SNELCAS) Referral Form**  Date of GP decision to refer: No. of pages sent:  Email: [suffolkcommunityhealthcare.referrals@nhs.net](mailto:suffolkcommunityhealthcare.referrals@nhs.net) | | | | | | | | | | |
| **INFORMATION PROVIDED TO PATIENT (To be provided by referring Clinician) please tick if yes** | | | | | | | | | | |
| Patient is aware of possible diagnosis of Long Covid | | | | | | | | |  | |
| Approximate date of infection (referrals only accepted for patients with symptoms over 12 weeks): | | | | | | | | | | |
| Patient has been given Yorkshire Rehabilitation Screening Tool to complete (referrals cannot be actioned until this is received) | | | | | | | | |  | |
| Patient’s preferred method of communication: Home number  Mobile  Email | | | | | | | | | | |
| Please confirm a medical assessment has taken place to exclude other possible causes of the patient's symptoms: Virtual  Face to Face | | | | | | | | |  | |
| **PATIENT DETAILS** – **Must provide current telephone number** | | | | | | | | | | |
| Last name: | |  | | | | First name: | |  | | |
| Gender: | |  | | | | DOB: | |  | | |
| Ethnicity: | |  | | | | Age: | |  | | |
| NHS No: | |  | | | | | | | | |
| Address: | |  | | | | | | | | |
| Tele (Day): | |  | | | | Tele (Evening): | |  | | |
| Mobile No: | |  | | | | Patient happy for a message to be left | | | |  |
| Email: | |  | | | | | | | | |
| **GP DETAILS** | | | | | | | | | | |
| GP name: | |  | | | | | | | | |
| Practice Code: | |  | | | | | | | | |
| Address: | |  | | | | | | | | |
| Telephone: | |  | | | | | | | | |
| Practice email: | |  | | | | | | | | |
| **WHO PERFORMANCE STATUS (pre Covid)** | | | | | | | | | select one | |
| 0 | Fully active, able to carry on all pre-disease performance without restriction | | | | | | | |  | |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out  light/sedentary work, e.g. house or office work. | | | | | | | |  | |
| 2 | Ambulatory and capable of self-care, but unable to carry out work activities.  Up and active more than 50% of waking hours. | | | | | | | |  | |
| 3 | Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours. | | | | | | | |  | |
| 4 | Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair. | | | | | | | |  | |
| **ADDITIONAL CONSIDERATIONS**  Please tick if the answer is yes to any of the questions below and give further information | | | | | | | | | | |
| Language/Hearing difficulties? | | | |  | | |  | | | |
| Learning difficulties? | | | |  | | |
| Mental capacity assessment required? | | | |  | | |
| Known safeguarding concerns? | | | |  | | |
| Do you have any objection to your patient being contacted for research purposes? | | | |  | | |
| **BACKGROUND INFORMATION/RISK FACTORS** | | | | | | | | | | |
| BMI | | |  | | Smoker/ex-smoker | | | |  | |
| Alcohol | | |  | | Other please specify | | | |  | |
| Relevant family history | | |  | | | | | | | |

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| |  |  | | --- | --- | | **MAIN REASON FOR REFERRAL** | | | 1. Persistent SOB |  | | 1. Malaise / fatigue |  | | 1. Chest pain |  | | 1. Psychological health |  | | 1. Other (please specify) | |   **Clinical triage is a crucial element of assessment so please give as comprehensive history and examination findings as possible, and ensure ALL pre-referral tests are requested, or referrals may be returned.**   |  | | --- | | **ESSENTIAL FILTER TESTS AND INVESTIGATIONS** | | It is mandatory to do all the following blood tests before referral; please tick the box to confirm they have been done.  FBC, ESR, U&E, TFT, HbA1c, LFT, bone profile, C19 serology | | CXR (required if the patient has not already had one and they have continuing respiratory symptoms) | | Resting oxygen saturation \_\_ % |  |  | | --- | | **CLINICAL INFORMATION (OR ATTACH LETTER)** | |  | |

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| --- | --- | --- |
| **PATIENT MEDICAL HISTORY** | | |
| **Existing conditions (please list or attach summary)** |  | |
| **Current medication (please list or attach list with indications)** |  | |
| **Allergies** |  | Details: |
| **Anticoagulants/Antiplatelets** |  | Details: |
| **Immunosuppressants** |  | Details: |
| **Diabetic** |  | Details: |