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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 |
| **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 outlight/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)
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**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.**

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| **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 \_\_ % |

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| **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: |