SNEE ICS Long Covid Assessment Service (SNELCAS) Referral Form

Date of GP decision to refer: No. of pages sent:

Email: ccc.snelcas@esneft.nhs.uk

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			

MAIN REASON FOR REFERRAL	
1. Persistent SOB	☐
2. Malaise / fatigue	☐
3. Chest pain	☐
4. Psychological health	☐
5. 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)

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: