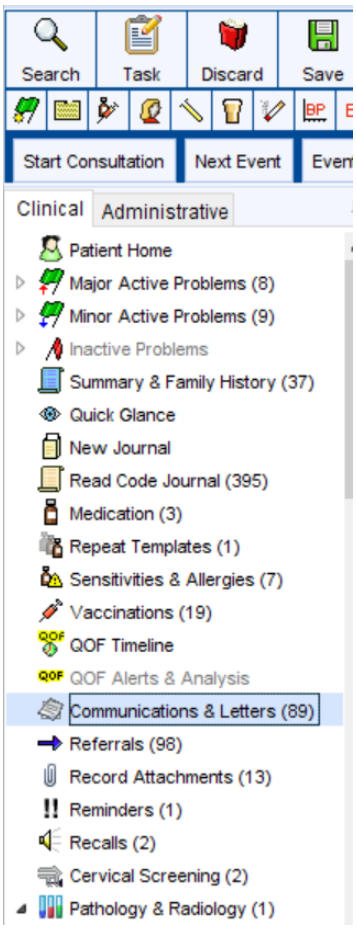
Long COVID referral process for practices using SystmOne

Where to locate the form

The Post COVID Specialist Assessment Clinic Referral Form (Onecontact) CEG v7 is located in Communications & Letters:



Post-COVID Specialist Assessment Clinic & COVID Rehabilitation Service

Referral Form for GPs

The service is for patients (18 and over) who are reporting Post COVID syndrome symptoms – i.e. ongoing symptomatic COVID for 12 weeks+ after confirmed or probable infection – AND who need a programme of physical and/or psychological therapy.

After primary care has carried out a standard and holistic **face to face assessment** taking into account their physical, mental and emotional health as well as undertaking any symptom-specific workup.

Patients should only be referred once an alternative cause for their symptoms has been excluded and where a Post-COVID Syndrome is thought to be the most suspected or likely cause for their presentation.

Exclusion Criteria

- *Symptoms which are acute or life-threatening, or symptoms where alternative causes have not been ruled out.*
- *A Standard assessment - as per NHS London guidance - has not been completed in the Primary Care or Specialist Assessment Clinic setting. This includes all mandate tests as outlined below.*
- *Any person under the age of 18 years old.*

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/C1248-national-guidance-post-covid-syndrome-assessment-clinics-v2.pdf

PATIENT INFORMATION	
First name	Micheal
Surname	Mouse-TestPatient
D.O.B	05 Jul 1954
NHS number	
Gender/Transgender identifier	M
Patient Address	36 Barking IG11 8PY
Patient Home Number	
Patient Mobile Number	07711 558169
Residential status	
Ethnicity	African - ethnic category 2001 census
Main Language	language not specified
Interpreter needs	N/A
Communication needs	N/A
Please confirm that a face to face review has been undertaken before referral	☐ Yes, a face to face review has been completed
Please confirm that the patient is not already under another Post-COVID service	☐ Patient is NOT under another Post COVID Service
CLINICAL OVERVIEW	

CO-MORBIDITY	
Diabetes	No event found
Hypertension	01 Jan 2003, Essential hypertension

	20 Mar 2013, Hypertension
Chronic kidney disease	No event found
Ischaemic heart disease	Angina, 13 Apr 2001
Cerebrovascular disease	No event found
Dementia	No event found
Chronic respiratory disease e.g. Asthma/COPD	No event found
Mental health problem e.g. depression, anxiety, personality disorder	17 Jul 2015, Depression NOS
Immunosuppression conditions	
Clinical Details	
Allergies	*Please see end of form*
Current Medication	*Please see end of form*
Smoking status	08 Oct 2021, Cigarette pack-years
Height	1.72 m
Weight	93 Kg
BMI	31.44 Kg/m²
Temperature	No event found
Alcohol status	08 Jan 2021, 50 Units/Week, 50, Units/Week

BEDSIDE TESTS REQUIRED	
Heart rate (resting level)	**09 Oct 2020, 65 bpm, 65, bpm 09 Oct 2020, O/E - pulse rate**
Pulse rhythm	**09 Oct 2020, O/E - pulse rhythm regular**
Oxygen saturations (resting level)	**No event found**
BP	**120 / 80 mmHg**
Standing BP	**No event found**
MRC breathlessness scale (mandatory if breathless) Pre COVID Post COVID	**No event found**
Other (1 minute sit to stand, 40 step walk, exertional heart rate, exertional saturations	**No event found**

BLOOD TESTS (WITHIN LAST 6 MONTHS)	
Full blood count Mandatory	**No event found**
eGFR Mandatory	**No event found**
Urea and electrolytes (Mandatory)	**No event found**
Liver function tests (Mandatory)	**No event found**
C-reactive protein (Mandatory)	**No event found**
Brain natriuretic peptide (Mandatory if breathless/cough/fatigue)	**No event found**
Troponin (consider if chest pain)	**No event found**
Ferritin (Mandatory)	**No event found**
Creatinine Kinase (Mandatory)	**No event found**
HbA1c (Mandatory if fatigue)	**No event found**
Cholesterol	**No event found**
Thyroid Function Test (Mandatory if fatigue)	**No event found**
Vitamin D Level (Mandatory if fatigue)	**No event found**
B12 Level (Mandatory if fatigue)	**No event found**
Serum Folate level (Mandatory if fatigue)	**No event found**
Bone Profile (Mandatory if fatigue)	**No event found** **No event found** **No event found** **No event found** **No event found**
If available:	
COVID-19 serology (Consider if no previously positive PCR results))	**No event found**
Date of previous positive COVID-19 swab (if performed)	**No event found**
Please attach any other relevant results of tests specific to symptoms eg 24hr holter (if palpitations), 24hr BP monitoring (if hypertension and headache), Transthoracic Echocardiogram results or other relevant imaging.	

OTHER TESTS (PERFORMED WITHIN THE LAST 4 WEEKS) (REQUIRED)	
Chest x-ray (Mandatory)	**<Diagnoses>**
Electrocardiogram (Mandatory if Chest Pain/Breathless/Fatigue)	**<Diagnoses>**

Referral Information	
Date of Referral	03 Dec 2021
Referral Source	Ilford Lane Surgery

Problems:

01 Jan 1995 00:00, Type II diabetes mellitus (X40J5)

01 Jan 1997 00:00, Seasonal allergic rhinitis (Xa0lX)

Allergies:

01 Jan 1991, Aspirin allergy (Xa5dq)

03 Dec 2004, Penicillin allergy (Xa5sH)

Medication:

11 Feb 2015, Methotrexate 2.5mg tablets

15 Jun 2017, Warfarin 3mg tablets

If you're using OneContact, you DO NOT need to include the following pages of the referral form.

If you are not using OneContact please ensure referral form includes this page of symptoms and the patient completes the questionnaires.

Symptoms

Core
No event found
20 Mar 2013, Fever symptoms

Respiratory
No event found

Cardiovascular
No event found
No event found

Mental Health
No event found
No event found
09 Dec 2014, Impaired cognition
No event found
No event found

Other
No event found
No event found
No event found
No event found
07 Sep 2013, Headache
No event found

Other: See consultation above.

Please print and ask the patient to fill out the following scoring questionnaires. Attach completed questionnaires to referral form.

Post COVID Functional Status Questionnaire

Name / ID patient	Micheal Mouse-TestPatient
Date of COVID-19 diagnosis	_____/ _____/ ____
Date of assessment of the PCFS scale	____/_____/____
Respondent(s)	Patient ☐ Patient and another person ☐ Only another person ☐ Specify:
Rater	Physician ☐

2. CONSTANT CARE Explanation: meaning someone else needs to be available at all times. Care may be provided by either trained or an untrained caregiver. The patient will usually be bedridden and may be incontinent.	Corresponding PCFS scale grade if the answer is 'YES'
2.1 Do you require constant care?	☐ Yes ☐ No **Score 4 if yes**

3. BASIC ACTIVITIES OF DAILY LIVING (ADL) Explanation: assistance includes physical assistance, verbal instruction, or supervision by another person. It may be considered *essential* when there is a need for physical help (by another person) with an activity or for supervision, or the patient needs prompting or reminding to do a task. The need for supervision for safety reasons should be due to *objective danger* that is posed, rather than 'just in case'.	Corresponding PCFS scale grade if the answer is 'YES'
3.1 Is assistance essential for eating? (Eating without assistance: food and implements may be provided by others)	☐ Yes ☐ No **Score 4 if yes**
3.2 Is assistance essential for using the toilet? (Using toilet without assistance: reach toilet/commode; undress sufficiently; clean self; dress and leave)	☐ Yes ☐ No **Score 4 if yes**
3.3 Is assistance essential for routine daily hygiene? (Routine hygiene includes only washing face, doing hair, cleaning teeth/fitting false teeth. Implements may be provided by others without considering this as assistance)	☐ Yes ☐ No **Score 4 if yes**

3.4 Is assistance essential for walking? (Walking without assistance: if absolutely necessary, able to walk indoors or around house or ward, may use any aid, however not requiring physical help or verbal instruction or supervision from another person)	☐ Yes ☐ No **Score 4 if yes**

4. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (iADL) Explanation: assistance includes physical assistance, verbal instruction, or supervision by another person. It may be considered *essential* when there is a need for physical help (by another person) with an activity or for supervision, or the patient needs prompting or reminding to do a task. The need for supervision for safety reasons should be due to *objective danger* that is posed, rather than 'just in case'.	Corresponding PCFS scale grade if the answer is 'YES'
4.1 Is assistance essential for basic household chores which are important for daily life? (E.g. preparing a simple meal, doing the dishes, take out the garbage; exclude chores that do not need to be done every day)	☐ Yes ☐ No **Score 4 if yes**
4.2 Is assistance essential for local travel? (Local travel without assistance: the patient may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the patient can manage to call and instruct the driver)	☐ Yes ☐ No **Score 4 if yes**
4.3 Is assistance essential for local shopping? (The patient is not able to buy groceries or necessities by him or herself)	☐ Yes ☐ No **Score 3 if yes**

5. PARTICIPATION IN USUAL SOCIAL ROLES Explanation: this section concerns impairment in fulfilment of major social roles (not social or financial circumstances).	Corresponding PCFS scale grade if the answer is 'YES'
5.1 Is adjustment essential for duties/activities at home or at work/study because you are unable to perform these yourself (e.g. resulting in a change in the level of responsibility, a change from full-time to part-time work or a change in education)? (Work refers to both paid employment and voluntary work. Special arrangements which allow someone to return to work, even though normally he/she wouldn't be able to work, should be considered as adjustment of work.)	☐ Yes ☐ No **Score 3 if yes**
5.2 Do you occasionally need to avoid or reduce duties/activities at home or at work/study or do you need to spread these over time (while you are basically able to perform all those activities)?	☐ Yes ☐ No **Score 2 if yes**
5.3 Can you no longer take good care of loved ones as before? (Taking good care includes babysitting, looking after your partner, parents, grandchildren or dependent others.)	☐ Yes ☐ No **Score 3 if yes**
5.4 Since the COVID-19 diagnosis, have there been problems with relationships or have you become isolated? (These problems include communication problems, difficulties in relationships with people at home or at work/study, loss of friendships (increase in) isolation, etc.)	☐ Yes ☐ No **Score 3 if yes**
5.5 Are you restricted in participating in social and leisure activities? (Comprising hobbies and interests, including going to a restaurant, bar, cinema, going for walks, playing games, reading books, etc.)	☐ Yes ☐ No **Score 2 if yes**

6. SYMPTOM CHECKLIST Explanation: these can be any symptoms or problems reported by the patients or found on physical examination. Symptoms include but are not limited to: dyspnoea, pain, fatigue, muscle weakness, memory loss, depression and anxiety.	Corresponding PCFS scale grade if the answer is 'YES'
6.1 Do you report symptoms through which usual duties/activities need to be avoided, reduced or spread over time?	☐ Yes ☐ No Score 2 if yes
6.2 Do you report any symptoms, resulting from COVID-19, without experiencing functional limitations?	☐ Yes ☐ No Score 1 if yes
6.3 Do you have problems with relaxing or do you experience COVID-19 as a trauma? ('Trauma' is defined as: suffering from intrusive memories, flashbacks or avoidance responses, associated with having experienced COVID-19.)	☐ Yes ☐ No Score 1 if yes

Assigning a grade on the post-COVID-19 functional status scale

The overall rating is simply the poorest functional status indicated by the patient's answers (the highest grade corresponds with the most limitations).

If a respondent has no limitations or symptoms, then the appropriate scale grade is 0.

Final PCFS scale grade:

Yorkshire Screening Tool Questionnaire

Below are some questions about how you might have been affected since your illness. If there areother ways that you've been affected, then there will be a chance to describe these at the end.			
1. Breathlessness	On a scale of 0-10, with 0 being not breathless at all, and10 being extremely breathless, how breathless are you: (n/a if does not perform this activity)	Now	Pre-Covid
	a) At rest?	0-10:	0-10:
	b) On dressingyourself?	0-10: N/A ☐	0-10: N/A ☐
	c) On walking up aflight of stairs?	0-10: N/A ☐	0-10: N/A ☐
2. Laryngeal/ airway complications	Have you developed any changes in the sensitivity of your throat such as troublesome cough or noisy breathing? Yes ☐ No ☐ If Yes: rate the significance of impact on a scale of 0-10(0 being no impact, 10 being significant impact) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐		
3. Voice	Have you or your family noticed any changes to your voice such as difficulty being heard, altered quality of the voice, your voice tiring by the end of the day or an inability to alter the pitch of your voice? Yes ☐ No ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐		
4. Swallowing	Are you having difficulties eating, drinking or swallowing such as coughing, choking or avoiding any food or drinks? Yes ☐ No ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐		

5. Nutrition	Are you or your family concerned that you have ongoing weight loss or any ongoing nutritional concerns as a result of COVID-19? Yes ☐ No☐ Please rank your appetite or interest in eating on a scale of 0-10 since COVID-19: (0 being same as usual/no problems, 10 being very severe problems/ reduction) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
6. Mobility	On a 0-10 scale, how severe are any problems you have in walkingabout? (0 means I have no problems, 10 means I am completely unable to walkabout) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
7. Fatigue	Do you become fatigued more easily compared to before your illness? Yes ☐ No ☐ If yes, how severely does this affect your mobility, personal cares, activities or enjoyment of life? (0 being not affecting, 10 being very severely impacting)
	Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
8. Personal-Care	On a 0-10 scale, how severe are any problems you have in personalcares such as washing and dressing yourself? (0 means I have no problems, 10 means I am completely unable to do my personal care) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
9. Continence	Since your illness are you having any new problems with: • controlling your bowel Yes ☐ No ☐ • controlling your bladder Yes ☐ No ☐
	On a 0-10 scale, how severe are any problems you have in do your usual activities, such as your household role, leisure activities, work or study? (0 means I have no problems, 10 means I am completely unable to do myusual activities) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
11. Pain/ discomfort	On a 0-10 scale, how severe is any pain or discomfort you have? (0 means I have no pain or discomfort, 10 means I have extremely severepain) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
12. Cognition	Since your illness have you had new or worsened difficulty with: • concentrating? Yes ☐ No ☐ • short term memory? Yes ☐ No ☐
13. Cognitive-Communication	Have you or your family noticed any change in the way you communicatewith people, such as making sense of things people say to you, putting thoughts into words, difficulty reading or having a conversation? Yes ☐ No ☐ If Yes: rate the significance of impact on a scale of 0-10(0 being no impact, 10 being significant impact) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
14. Anxiety	On a 0-10 scale, how severe is the anxiety you are experiencing?(0 means I am not anxious, 10 means I have extreme anxious) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

15. Depression	On a 0-10 scale, how severe is the depression you are experiencing?(0 means I am not depressed, 10 means I have extreme depression) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
16. Global Perceived Health	How good or bad is your health overall? 10 means the best health youcan imagine. (0 means the worst health you can imagine) Now: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Pre-COVID: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

17. Vocation	What is your employment situation and has your illness affected your ability to do your usual work? Occupation: Employment status before COVID-19 Lockdown: Employment status before you became ill: Employment status now:
18. Family/Carer's views	Do you think your family or carer would have anything to add from their Perspective?

Closing questions:

Are you experiencing any other new problems since your illness that haven't been mentioned above?

EQ-5D-3L Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems in walking about ☐
- I have some problems in walking about ☐
- I am confined to bed ☐

SELF-CARE

- I have no problems with self-care ☐
- I have some problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

- I have no problems with performing my usual activities ☐
- I have some problems with performing my usual activities ☐
- I am unable to perform my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.0 means the worst health you can imagine.
- Please mark an X on the scale to indicate how your health is TODAY.
- Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY

The best healthyou can imagine

Work and Social Adjustment Scale Questionnaire

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problem's, look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

If you're retired or choose not to have a job for reasons unrelated to your problem, tick here ☐

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

Because of my problem, my **ability to work** is impaired. '0' means not at all impaired and '8' means very severely impaired to the point I can't work:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Because of my problem, my **home management** (cleaning, tidying, shopping, cooking, looking after children or home, paying bills) is impaired:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Because of my problem, my **social leisure activities** (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Because of my problem, my **private leisure activities** (done alone – such as reading, gardening, collecting, sewing, walking alone) are impaired:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Because of my problem, my ability to form and maintain **close relationships** with others, including those I live with is impaired:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐