**SOMERSET POST COVID-19 ASSESSMENT SERVICE REFERRAL FORM**

**Referrals to be sent to** [**somccg.longcovid@nhs.net**](mailto:somccg.longcovid@nhs.net)

|  |  |  |
| --- | --- | --- |
| **REFERRER DETAILS** | **PATIENT DETAILS** | |
| Name: | Name: | DOB: |
| Organisation: |  | Gender: |
| Address: | Address: | Ethnicity: |
| Hospital No.: |
| NHS No.: |
| Tel No: | Tel No. (1): | *Please check telephone numbers* |
|  |
| Email: | Carer requirements (has dementia or learning disabilities)? | Does the patient have the capacity to consent?  Yes  No |
| **Decision to Refer Date:** | Translator Required: Yes  No  Language: | Mobility: Independent  Walks with stick  Wheelchair |
|  | Is there a positive Covid 19 Swab Result?  Yes  No  Date: |  |

|  |  |  |
| --- | --- | --- |
| |  |  | | --- | --- | | **Clinical details**  *Please document unexplained symptoms of concern and detail your conclusions and what needs to be excluded or attach a referral letter. Please include details of any physical findings as well as other important clinical information.*  **When did the patient get Covid 19 and what were the main symptoms?**  **Was the patient admitted to hospital?**  **Was the patient in intensive care?** |  | |
|  |

|  |
| --- |
| **Please give details of the symptoms the patient is experiencing now** |
|  |

|  |
| --- |
|  |
| P**lease give details of any blood results and other investigations you have done:** |

|  |
| --- |
|  |

|  |
| --- |
|  |

|  |
| --- |
| Is the person   * 1. o With a learning disability/autism/hearing loss/visual impairment/prior diagnosis of dementia   2. o From the criminal justice system   3. o Homelessness or rough sleeping   4. o A refugee or asylum seeker   5. o From Gypsy, Traveller, or Roma communities   6. o In full time education |
| **Is the patient able to manage a virtual consultation which may be done online or by phone?** |
| **Please attach the additional clinical issues list from your practice system**  **Details to include:**  Current medication, significant issues, allergies, relevant family history, alcohol status and morbidities |
|  |

***For clinic to complete*** UBRN: Received date: