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

**Referrals to be sent to** **somccg.longcovid@nhs.net**

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| **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* |
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| 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:  |  |

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| **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?** |  |

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| **Please give details of the symptoms the patient is experiencing now** |
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| P**lease give details of any blood results and other investigations you have done:** |

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