**COVID COORDINATOR REHAB REFERRAL FORM**

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| DATE OF REFERRAL: Click here to enter a date. |
| Does the patient have mental capacity to agree to this referral? Y [ ]  N [ ]  Has this referral has been discussed with the patient and the patient consents to relevant information being shared with the service provider(s) Y [ ]  N [ ] Patient consent will include provider access to Summary Care Records, if consent not obtained, please provide further details:Does clinician have consent to discuss with patient’s relative Y [ ]  N [ ] . If yes state relatives name and number (Next of Kin / Main Carer):  |
| **PATIENT DETAILS** |
| Title: Click here to enter text. | Surname: Click here to enter text. | First Name: Click here to enter text. |
| NHS No: Click here to enter text. | Date of Birth: Click here to enter a date. | Age: Click here to enter text. | Sex: Click here to enter text. |
| Home address: Click here to enter text. | Postcode: Click here to enter text. |
| Preferred No [ ]  Patient Home Contact No: Click here to enter text. Preferred No [ ]  Patient Mobile Contact No: Click here to enter text.  | Voicemails can be left? Y [ ]  N [ ]  Voicemails can be left? Y [ ]  N [ ]  |
| Ethnicity: Click here to enter text. | Language: Click here to enter text. | Interpreter Required? Y [ ]  N [ ] Does the patient have hearing issues? Y [ ]  N [ ]  |
| Smoking Status:  | Allergies:  |
| Does the patient have a DNACPR? Y [ ]  N [ ]  If “Yes” is there a copy in the patient’s home? Y [ ]  N [ ]  |
| Past Medical History (please detail previous function/mobility): |
| **Covid Status:**Suspected COVID [ ]  Date: Date of onset of symptoms: Test(s) Positive [ ]  Date: Duration of symptoms:Negative [ ]  Date: |
| **Brief description of initial symptoms:** Fever [ ]  Cough [ ]  Anosmia [ ]  SOB [ ]  Other (please state): |
| **Management: (Please send ALL relevant information on care)**[ ]  Home [ ]  A&E [ ]  Hospital admission [ ] ITU [ ]  Outpatient clinic |
| **Investigation already completed (Please send results and details of any future appointments):**[ ]  Bloods [ ] CXR [ ] Echo [ ] CT/CTPA [ ] Other (please state): |
| **The below are mandatory for referral acceptance.**SpO2: BP: RR: HR:Bloods (please attach any details) – FBC, U&Es, LFTs, CRP, Haematinics, Calcium [ ]  BNP [ ]  (required if heart failure suspected) |
| **REASON FOR REFERRAL - Please indicate reasons for referral.**  |  |
| [ ]  Ongoing Cough[ ]  Ongoing SOB[ ]  Ongoing Fatigue[ ]  Chest Pain [ ]  Has IHD/PE been excluded  | [ ]  Swallowing issues[ ]  Weight Loss[ ]  Mobility Issues[ ]  Memory/Cognitive[ ]  Dizziness/Balance Issues | [ ]  Anxiety / PTSD[ ]  Low Mood[ ]  Neurological Issues[ ] Pressure Ulcers/Skin issues |
| **Please give a brief outline of the ongoing problems and what has been tried so far:** |
| **Were any of the symptoms above present prior to their COVID illness?** Y [ ]  N [ ]  |
| **Is the patient under the care of any other services post COVID19?** Y [ ]  N [ ]  (If yes please state):  |
| Name of Referrer: Click here to enter text.Profession: Click here to enter text.Organisation/Practice Code: Click here to enter text.Contact No: Click here to enter text. | GP Practice: Click here to enter text.GP Practice Contact No: Click here to enter text.GP Alternative Contact No: Click here to enter text.GP Practice E-mail Address: Click here to enter text. |
| GP/Referrer Signature: Click here to enter text. | Date:Click here to enter a date. |