**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. | |