**LONG COVID Staff Support Service Referral Form**

**Please note: This service is appropriate for NHS and Health and Social Care Colleagues with physical or mental difficulties due to ongoing symptoms of COVID >4 weeks**

|  |  |  |
| --- | --- | --- |
| Date of referral: |  | |
| Usual GP:  GP Organisation:  Contact No: Email: | | |
| Staff member information | | |
| NHS No |  | |
| Surname: | First Name: | |
| Title: | Gender: | D.O.B: |
| Address:  Postcode: | Tel: | |
| Mobile: | |
| Preferred Email: | |
| Preferred contact method:  Telephone  Email | | |
| Ethnicity: | Language spoken: | |
| Job title:  Site of work:  Department/ward:  Currently at work:  Yes  No  If yes, on light duties:  Yes  No  Planned return date if applicable: | | |
| As a Service User do you consent for information to be shared with relevant support services within Derbyshire including Long COVID Community Clinic and Trent PTS:  Yes  No | | |
| Have you had input from Occupational Health for current symptoms:  Yes  No | | |
| Main symptoms: | | |
| Other health conditions: | | |
| Active Problems: | | |
| What was your health like before you had Covid?  I did not have any restrictions on my life / I had some restrictions, eg mobility / I had existing restrictions on my life | | |
| Current Medications: | | |
| Allergies: | | |
| What and when were the last investigations you had?  Please contact [uhdb.longcovidsupport@nhs.net](mailto:uhdb.longcovidsupport@nhs.net) if initial investigations have not yet been carried out by your GP to rule out other causes of symptoms and we can support you in arranging this. | | |

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| --- | --- |
| **Reason for Referral:** | |
| **Section 1. Covid-19 Diagnosis**  **EITHER** This would be at the acute stage via PCR or similar test:  If yes please indicate date of test: | Yes  No   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **OR** Covid-19 Antibody test has proved positive:  If yes please indicate date of test: | Yes  No   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **If no positive COVID test:**  What are clinical indications for suspecting that you have had COVID-19? | |
| **Section 2. Duration:**  Please provide approximate date of first significant Covid-19 symptoms:  Was patient hospitalised with COVID symptoms? If so, what were the dates of hospital admission? | |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  |   From:   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  |   To:   |  |  |  | | --- | --- | --- | | DD | MM | YY | |  |  |  | |
| **Section 3. Persistent Symptoms**   |  |  | | --- | --- | | **Symptom/s** | **Present** | | Fatigue | Yes No | | Shortness of breath\* | Yes No | | Persistent coughing | Yes No | | Headaches | Yes No | | Muscle/joint pain | Yes No | | Weakness/ reduced mobility | Yes No | | Poor sleep | Yes No | | Weight loss/ poor nutrition/ difficult swallow | Yes No | | Cognitive signs/ poor concentration | Yes No | | Other (please state): |  |   *If there is ongoing shortness of breath, please request a referral for chest x-ray from your GP, we are happy to support you in requesting this.* | |
| **Section 4. Psychological Assessment**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) | | Little interest or pleasure in doing things? |  |  |  |  | | Feeling down, depressed, or hopeless? |  |  |  |  | | Feeling nervous, anxious or on edge? |  |  |  |  | | Not being able to stop or control worrying? |  |  |  |  | | Thoughts of thinking I would be better off dead or thoughts of hurting myself |  |  |  |  |   *Total:   /15* | |

**Please tick the descriptions in each column that best describes how you currently feel so that a Clinician can refer you to the appropriate services for your symptoms:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Score** | **Breathing** | **Mobility/Activity** | **Energy levels** | **Mood** | **Thinking** |
| **NORMAL** | **Back to normal** | **Back to normal** | **Able to manage all usual activities as normal** | **My mood is basically ok** | **I can think clearly and my mental ability is basically ok** |
| **MILD** | **Not normal but I can do everything** | **Nearly back to normal** | **Feeling tired but managing normal activities** | **I am OK apart from moments of low mood or anxiety** | **I am OK apart from brief thinking lapses** |
| **MODERATE** | **Breathless on hills/stairs/ walking fast** | **Having to move more slowly, but doing everything** | **Feeling tired, needing to rest frequently, restricting normal activities** | **Most days I have low mood or anxiety** | **Most days I have some difficulty with memory, concentration or word finding** |
| **SEVERE** | **Stops me doing some things** | **Struggling with some activities** | **Significant tiredness, occasionally unable to participate in normal activities** | **My mood or anxiety is having a significant effect on my usual activities** | **My memory or concentration is now poor and I struggle to think** |
|  | **Breathless on minimal activity** | **Barely getting around** | **Significant tiredness, unable to participate in normal activities each day** | **I feel suicidal and hopelessness** | **I just cannot think or remember and this is having a significant effect on my usual activities** |
|  | **Breathless at rest** | **Bed bound** | **Fatigue is debilitating and persistent, dependent on others for all tasks** | **I hear voices or I am losing my grip on reality or I have harmed myself** | **I am forgetting or unable to do important tasks that put me or others at risk of harm** |

**Please return completed form to** [**uhdb.longcovidsupport@nhs.net**](mailto:uhdb.longcovidsupport@nhs.net) **prior to your initial well-being consultation**