**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 [ ]  NoIf yes, on light duties: [ ]  Yes [ ]  NoPlanned 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 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. |

|  |
| --- |
| **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

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| --- | --- | --- |
| DD | MM | YY |
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| **OR** Covid-19 Antibody test has proved positive:If yes please indicate date of test: | [ ]  Yes[ ]  No

|  |  |  |
| --- | --- | --- |
| DD | MM | YY |
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| **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? |

|  |  |  |
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| DD | MM | YY |
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From:

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| --- | --- | --- |
| DD | MM | YY |
|  |  |  |

To:

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| --- | --- | --- |
| DD | MM | YY |
|  |  |  |

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| **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** **prior to your initial well-being consultation**