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POST-COVID-19 INTERDISCIPLINARY CLINICAL CARE NETWORK (PC-ICCN) REFERRAL

Referral Other

Referral Date: ______________________

∗ Required fields must be completed or Referral will NOT be processed.

Referrals to the PC-ICCN are for patients who are experiencing persistent symptoms for **more than 3 months following a presumed or confirmed COVID-19 illness** that are impacting their daily living**.** This referral is **NOT** for cases requiring urgent care. Please see page 2 for additional referral guidelines.

Patients will be contacted and assessed by the Central Triage RN, who will determine the appropriate level of resources and services required to support this patient's recovery. **NOTE: not all referrals will result in a clinic visit.**

Fax completed referral to Post-COVID Central Triage: 604-806-8809. We will contact your patient directly.
If you require further support or have questions regarding your post-COVID patient, please request advice from "General Internal Medicine – COVID-19-Long Term Sequelae" via the RACE app: http://www.raceconnect.ca/race-app/

REFERRING CLINICIAN

Name: ______________________ MSP Number: __________

Phone: ______________ Fax: ______________ Email: ______________

FAMILY PHYSICIAN: (if different from referring clinician) ______________________ MSP Number: __________

Phone: ______________ Fax: ______________ Email: ______________

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ Middle Initial: ______

PHN: ______________ DOB: (dd/mmm/yyyy) ______________ Gender: ☐ Male ☐ Female ☐ Other: ______

Patient address: ______________________

City / Town: ______________ Postal Code: ______________

Patient phone number: ______________ Email: ______________

Alternate contact - Name: ______________ Phone: ______________

Relationship to patient: ______________

Is a translator required? ☐ No ☐ Yes If YES, language: ______________

CLINICAL INFORMATION

Date of symptom onset: (dd/mmm/yyyy) ______________ *∗ Referrals will only be accepted 3 months after symptom onset.*

Does patient have a positive COVID-19 test? ☐ No ☐ Yes Date: (dd/mmm/yyyy) ______________

Patient admitted to hospital: ☐ No ☐ Yes Date of hospital discharge: (dd/mmm/yyyy) ______________

ICU admission: ☐ No ☐ Yes Date admitted to ICU: (dd/mmm/yyyy) ______________

REASON FOR REFERRAL *∗ Required field. - will be used for triage purposes*

Category A	☐ Hospitalization for COVID-19 ☐ 2 or more ER presentations following diagnosis of COVID-19 ☐ New evidence of end organ impairment without identifiable cause: (check all that apply and attach relevant documents) ☐ cardio ☐ neuro ☐ resp ☐ renal ☐ musculoskeletal
Category B	☐ NYHA dyspnea scale 3 or higher (new finding) ☐ Inability to return to work or school post diagnosis of COVID-19 for 12 or more weeks ☐ Functional deterioration post diagnosis of COVID-19 (dependence on ADLs or iADLs) for 12 or more weeks
Category C	☐ Unexplained, persistent symptoms for more than 12 weeks related to presumed or confirmed COVID-19 infection. ☐ fatigue ☐ brain fog ☐ shortness of breath ☐ chest pain ☐ palpitations ☐ headaches ☐ other: ______________ *(please list)*

Please confirm that you have done full history, physical examination and relevant investigations as part of differential diagnoses and to rule out other conditions explaining the symptoms. (*see page 2 for specific workup requirements*) ☐ YES ☐ NO

Any other relevant diagnoses/information: ______________________

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REFERRING CLINICIAN CHECKLIST

- ☐ Ensure ALL clinician information is provided, including email addresses.
- ☐ Ensure ALL patient demographic and contact information is provided, including email addresses.
- ☐ Document known clinical information and attach any relevant documents to ensure patient is appropriately triaged by our network.(See clinical workup checklist)
- ☐ Provide your patient with the PHSA website for self-care resources: www.phsa.ca/postCOVID

Fax completed referral to Post-COVID Central Triage: 604-806-8809.

Patients will be assigned to clinics based on factors such as home address and wait times.

CLINICAL WORKUP CHECKLIST*

*Abnormal results must be addressed by the ordering provider

- ☐ **Fatigue**
  - ☐ CBC, ferritin, TSH, B12
  - ☐ OSA testing *(if high risk)*
  - ☐ PHQ-9 for depression
  - ☐ GAD-7 for anxiety
- ☐ **Brain fog**
  - ☐ CBC, ferritin, TSH, B12
  - ☐ OSA testing *(if high risk)*
  - ☐ PHQ-9 for depression
  - ☐ GAD-7 for anxiety
- ☐ **Shortness of breath**
  - ☐ CXR
  - ☐ Spirometry *(if bronchospasm)*
- ☐ **Chest pain**
  - ☐ ECG
  - ☐ BNP
  - ☐ CXR
- ☐ **Palpitations**
  - ☐ ECG
  - ☐ Holter monitor
- ☐ **Rash**
  - ☐ Dermatology consult
- ☐ **Loss of taste/smell**
  - ☐ ENT consult

*Note: if these workups are not complete, referral will be declined.

POST-COVID INTERDISCIPLINARY CLINICAL CARE NETWORK (PC-ICCN) GUIDELINES

- Patients must be willing to engage in self-management activities
- There is no COVID-19 diagnostic requirement to be eligible for referral
- Referrals will only be accepted from a medical doctor or a nurse practitioner
- The PC-ICCN does not accept re-referrals following discharge for the clinic. If you believe your patient requires re-entry into the network, please use the RACE app to have the case reviewed
- Referrals for pre-existing symptoms/concerns should not be made to the PC-ICCN
- **Please encourage your patient to review recovery information on our website:** http://phsa.ca/PostCovid

FOR GENERAL INQUIRIES VISIT: www.phsa.ca/postCOVID **OR EMAIL:** post-COVID-ICCN@phsa.ca