POST-ACUTE COVID-19 PROGRAM REFERRAL FORM

NOTE: Currently, ONLY PATIENTS ≥18 YEARS OF AGE FROM LONDON-MIDDLESEX will be accepted and MUST meet ALL of the following criteria:

1. Confirmed COVID-19 infection (PCR, RAT, or Anti-SARS-CoV-2 Antibody Testing)

[AND]

2. Cumulative of **≥12 weeks** of on-going or intermittent symptomatology post COVID-19 infection**. ***We will not be accepting patients whose symptomatology is due to a pre-existing **non-cardiopulmonary** health condition, exacerbated by COVID-19

[AND]

3. Basic differential workup and imaging has been started to rule out other potential aetiologies

[AND]

4. Support is not being received elsewhere for these concerns (i.e. WSIB, other specialists)

The Post-Acute COVID-19 Program offers ambulatory care for people who have had COVID-19. Patients are triaged based on the urgency of medical review and impact on quality of life. Please send completed form via fax: **(519) 646-6162**, or email: **postacutecovidprogram@sjhc.london.on.ca**.

Note: it may take up to 6-months before your patient will receive an appointment date and time

Please fill in all necessary components to ensure a timely triage process

Date: select

Patient Information			
Surname:	Given & Preferred Name:	Gender:	DOB:
OHIP # with Version Code:	Contact:.		Alternate:
Address - # and Street:	City:	Province:	Postal Code:
Email:			
Alternate Contact:	Relationship to Patient:	Contact:	
Date of Positive COVID-19 Test: Type of Test:	MRN:	Interpreter Required: ☐ Yes ☐ No Language:	

Pre-COVID-19 Conditions:

- ☐ CAD
- ☐ Diabetes
- ☐ CKD
- ☐ Obesity
- ☐ Sleep Apnea
- ☐ COPD and/or Asthma
- ☐ Malignancy (specify):
- ☐ Neuromuscular Disorder (specify)
- ☐ Coagulopathy (specify):
- ☐ Autoimmune Disorder (specify):
- ☐ Cognitive Impairment/Dementia
- ☐ Mental Health Diagnosis
- ☐ Chronic Pain Condition (specify):
- ☐ Other (specify):

COVID-19 Clinical Course: **Asymptomatic Initially**? ☐ Yes ☐ No **Date of Symptom Onset:** **Hospitalized**? ☐ Yes ☐ No – if yes, length of stay **Hypoxemic**? ☐ Yes ☐ No – If yes, oxygen needed/amount **On-going O_2**? ☐ Yes ☐ No

ICU Admission? ☐ Yes ☐ No COVID-19 vaccinated at time of infection? ☐ Yes ☐ No | # of vaccines during time of infection ____ | Current # of vaccines ____ **Other Details**:

Post-Acute COVID-19 Concerns: *(respiratory, cardiovascular, fatigue, neurocognitive, psychosocial, dermatological, gastrointestinal, sensory, musculoskeletal, and/or sleep)*

Details/Impact on Quality of Life:

Primary Care Provider:	**Contact:**	**Alternate:**
Referring Provider Reg. and OHIP Billing No.:		**Contact:**
Signature:		**Date**:

external version 2; 23/09/2022 MZ