

# POST COVID-19 RECOVERY CLINIC REFERRAL



Referral Other

Referral Date: \_\_\_\_\_

*\* Required fields must be completed or Referral will NOT be processed.*

**NOTE:** Referrals will only be accepted for:

- **Confirmed** COVID positive (NAAT or serology) or Official Epi-Linked cases.
- Individuals who were symptomatic January - May 2020 and did **NOT** have access to a COVID-19 test.

The Post COVID-19 Recovery Clinics are designed to see patients at **3 or more months post-symptom onset**.

This referral is **NOT** for cases requiring urgent care.

**Fax completed referral to Post COVID Central Triage: 604-806-8809.** We will inform patients of any scheduled appointments. If you require further support or have questions regarding your post COVID patient, please request advice from "COVID – GIM Post Infection Care" via the RACE app: <http://www.raceconnect.ca/race-app/>

REFERRING CLINICIAN		
Name: _____		MSP Number: _____
Phone: _____	Fax: _____	
Email Address: (to participate in care conferencing-billing code #14077) _____		
FAMILY PHYSICIAN: (if different from referring clinician) _____		
MSP Number: _____	Phone: _____	Fax: _____
Email Address: (to participate in care conferencing-billing code #14077) _____		
PATIENT INFORMATION		
Last Name: _____	First Name: _____	Middle Initial: _____
PHN: _____	DOB: (dd/mmm/yyyy) _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient address: _____		<input type="checkbox"/> Other: _____
City / Town: _____	Postal Code: _____	
Patient phone number: _____	Email: _____	
Alternate contact - Name: _____		Phone: _____
		Relationship to patient: _____
Is a translator required? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, language: _____		
CLINICAL INFORMATION		
Date of symptom onset: (dd/mmm/yyyy) _____		<i>* Required field</i>
Date of first positive COVID-19 test: (dd/mmm/yyyy) _____		<i>* Required field</i>
Patient admitted to hospital: <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of hospital discharge: (dd/mmm/yyyy) _____	
ICU admission: <input type="checkbox"/> No <input type="checkbox"/> Yes	Date admitted to ICU: (dd/mmm/yyyy) _____	
REASON FOR REFERRAL <i>* Required field. - will be used for triage purposes</i>		
<p style="text-align: center;"><b>Category A</b></p> <input type="checkbox"/> Hospitalization for COVID-19 <input type="checkbox"/> 2 or more ER presentations following diagnosis of COVID-19 <input type="checkbox"/> New evidence of end organ impairment without identifiable cause: (check all that apply) <input type="checkbox"/> cardio <input type="checkbox"/> neuro <input type="checkbox"/> resp <input type="checkbox"/> renal <input type="checkbox"/> musculoskeletal	<p style="text-align: center;"><b>Category B</b></p> <input type="checkbox"/> NYHA dyspnea scale 3 or higher (new finding) <input type="checkbox"/> Inability to return to work or school post diagnosis of COVID-19 for 12 or more weeks <input type="checkbox"/> Functional deterioration post diagnosis of COVID-19 (dependence on ADLs or iADLs) for 12 or more weeks	<p style="text-align: center;"><b>Category C</b></p> <input type="checkbox"/> Unexplained, persistent symptoms for more than 12 weeks post symptom-onset, thought to be related to COVID-19

**Referral Criteria, Referring Clinician Checklist on reverse.**

**POST COVID-19 RECOVERY CLINIC  
REFERRAL**

Attach Patient Label Here



Referral Other

**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.

**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.*

**POST COVID CLINICAL CARE NETWORK REFERRAL CRITERIA:**

- Patient is confirmed COVID-19 positive (NAAT or serology) or is Epi-Linked (BCCDC criteria)
- Patient was symptomatic January-May 2020 and did not have access to a COVID-19 test
- Patient is made aware and consents to attend appointment and investigations

**FOR GENERAL INQUIRIES VISIT:** <http://www.phsa.ca/our-services/programs-services/post-covid-19-recovery-clinics>

**OR EMAIL:** [post-COVID-ICCN@phsa.ca](mailto:post-COVID-ICCN@phsa.ca)

**POST COVID-19 CLINIC SITES:**

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

**PROVIDENCE HEALTH CARE:**

**St. Paul's Hospital Post-COVID-19 Recovery Clinic**

**VANCOUVER COASTAL HEALTH:**

**Vancouver General Hospital Post-COVID-19 Recovery Clinic**

**FRASER HEALTH:**

**Jim Pattison Outpatient Care and Surgery Centre Post-COVID-19 Recovery Clinic**

**Abbotsford Regional Hospital Post-COVID-19 Recovery Clinic**

**ISLAND HEALTH**

**Royal Jubilee Hospital Post-COVID-19 Recovery Clinic**