COVID-19 Recovery Clinic Referral Form

NOTE: This clinic is for patients who are > 10 weeks positive test for COVID-19. This clinic will not accept patients who are under 18 years of age or WCB patients.

Date of Referral: ______________________________

Patient demographics (or affix label):

Name:

DOB/Age: PHN:

Phone number: Gender:

Address:

COVID-19 testing: ☐ Confirmed ☐ Presumed

COVID-19 positive test date: (dd/mmm/yyyy): ________________________________

Symptoms

Please complete the following investigations since the onset of post-COVID symptoms and include them with the referral.

- ☐ Fatigue—CBCd, Cr/Electrolytes, ALT, HbA1C, Ferritin, TSHp
- ☐ Cognitive concerns: Cr/Electrolytes, TSHp, HbA1C, Vitamin B12
- ☐ Dyspnea: CBCd, Ferritin, CXR, ECG, PFT, Echocardiogram
- ☐ Chest Pain: CBC, Cr/Electolytes, Troponin, CXR, ECG, Echocardiogram
- ☐ Palpitations: CBCd, Cr/Electrolytes, Ferritin, TSHp, ECG, Holter (24 hr)
- ☐ Headache
- ☐ Sensory/Neuro: CBCd, HbA1C, TSHp, Ferritin, Vitamin B12
- ☐ Smell/Taste concerns
- ☐ Muscle/Joint pain: CBCd, CRP, CK
- ☐ Other ______________________

Please attach the patient's medical history and current medication list

Referring physician information (or stamp):

Name & PRAC ID:

Clinic name & address:

Clinic phone: Clinic fax:

Member of which PCN?:

Please fax your referral to 780-473-7181