

## LONG COVID ASSESSMENT CLINIC REFERRAL FORM

Email: [HealthRAHOPDReferrals@sa.gov.au](mailto:HealthRAHOPDReferrals@sa.gov.au)



**Health**  
Central Adelaide  
Local Health Network

Please complete all the information requested below to assist with triaging. Incomplete referrals will delay triaging. If your patient requires single discipline or allied health input only consider referral to alternative options. Information for health professionals on the assessment and management of Long COVID is available through the Health Pathways (Health pathways Login: covid19, Password: sapassword). A handout is also attached.

The following are some resources that patients can be directed to:

1. Long COVID patient support groups at <https://lungfoundation.com.au/blog/covid-survivor-support-group/>
2. Self-rehabilitation through <https://www.who.int/publications/m/item/support-for-rehabilitation-self-management-after-covid-19-related-illness>.
3. Information from The Long COVID Alliance including educational videos <https://batemanhorncenter.org/education/long-covid/>

### PATIENT DETAILS

PATIENT NAME:

DOB:

ADDRESS:

CONTACT NUMBER:

EMAIL (preferred mode of communication):

Referral to (multiple can be selected):

- Dr Angela Molga
- Dr Nicholas Farinola
- Dr Rami Tadros
- Dr Tam Le Cong
- First available: Dr Farinola, Dr Molga, Dr Tadros, Dr Le Cong
- Any doctor

### CLINIC ACCEPTANCE CRITERIA

- Confirmed infection on testing e.g. PCR, RAT
- At the time of referral, it is at least 12 weeks from the onset of the first infection with COVID-19
- Persistent and significant symptoms at least 2 months
- **RED FLAGS (DO NOT refer to this clinic. Refer for emergency management):**
  - Severe, new onset or worsening dyspnoea or hypoxia
  - Syncope
  - Unexplained chest pain, palpitations or arrhythmias where appropriate investigations have not been undertaken
  - New delirium or focal neurological signs
  - Severe psychiatric symptoms

**CLINICAL INFORMATION**

- Date of confirmed infection with a positive COVID-19 test \_\_\_\_/\_\_\_\_/\_\_\_\_
- Severity of the acute COVID infection:
  - 0, Asymptomatic: Individuals who test positive for SARS-CoV-2 using a virologic test (i.e., a nucleic acid amplification test [NAAT] or an antigen test) but who have no symptoms that are consistent with COVID-19
  - 1, Mild: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell) but who do not have shortness of breath, dyspnoea, or abnormal chest imaging
  - 2, Moderate: Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have an oxygen saturation measured by pulse oximetry (SpO2)  $\geq 94\%$  on room air at sea level.
  - 3, Severe: Individuals who have SpO2  $< 94\%$  on room air at sea level, a ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2)  $< 300$  mm Hg, a respiratory rate  $> 30$  breaths/min, or lung infiltrates  $> 50\%$ .
  - 4, Critical: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction

**SYMPTOMS AND LABORATORY INVESTIGATIONS**

Attach the following results to the referral: CBE, EUC, LFTs, then symptom specific

Indicate the symptoms present:

Symptoms	Present	If yes, investigation to be conducted and results attached
Fatigue with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bloods: Iron studies, vitamin B12 studies, thyroid function
Shortness of breath with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> D-dimer <input type="checkbox"/> Chest Xray if not contraindicated <input type="checkbox"/> CTPA or VA scan as clinically appropriate <input type="checkbox"/> Spirometry (handheld) if available or PFTS if done <input type="checkbox"/> Echocardiogram as appropriate
Muscle/joint pain with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bloods: ESR, CRP
Headaches with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bloods: ESR, CRP <input type="checkbox"/> Cerebral imaging as appropriate
Cognitive signs with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bloods: Vitamin B12 studies, Thyroid function <input type="checkbox"/> GPCog <a href="http://gpcog.com.au/index/patient-assessment">http://gpcog.com.au/index/patient-assessment</a> or equivalent <input type="checkbox"/> DASS-21 <input type="checkbox"/> Cerebral imaging as appropriate
Functional decline	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Post-COVID Functional Scale <input type="checkbox"/> Details:
Mental Health conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DASS-21

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Gastrointestinal symptoms with no alternative cause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ESR, CRP, antibody testing for coeliac disease
Sleep disturbance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DASS-21
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ECG, TFTs, Holter
Chest pain: PE and ischaemic heart disease ruled out	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> If no cardiovascular risk factors present: CXR, ECG, Echocardiogram <input type="checkbox"/> If cardiovascular risk factors present manage in line with national guidelines
Orthostatic intolerance/POTS-like symptoms/suspected POTS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ECG, Echo, Holter, TFTs, Iron studies, 10-minute lean test, d-dimer, CRP, ESR, troponin
Other symptoms:		

**VITAL SIGNS:**

Lying blood pressure and heart rate \_\_\_\_\_

Standing blood pressure and heart rate \_\_\_\_\_

Any symptoms reported on standing: \_\_\_\_\_

**ONE MINUTE SIT TO STAND TEST (Do not perform if patient is hypoxic at rest or other contraindications)**

**Instructions:**

1. Place the back of the chair against a wall to stop it moving whilst performing the test.
2. Before starting, measure the patient's oxygen levels and heart rate using a pulse oximeter and measure their breathlessness using the BORG breathlessness scale. Write down all the results.
3. Set a timer for one minute.
4. Ask the patient to sit down in the chair with feet flat on the floor.
5. Ask them to put their hands on their hips, let them hang by their sides or hold them loosely together.
6. Stand up from the chair until their legs are completely straight - making sure that they do not use their hands or arms to help. Then they can sit back down again. This counts as one sit to stand.
7. Ask them to continue sitting up and down on the chair as many times as they can in one minute and start the timer.
8. Resting is permitted, and they can continue when able.
9. Stop the test at any time if they feel unwell, have chest pain, dizziness, or severe breathlessness.

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10. When finished write down how many sit to stand exercises were completed in one minute.  
11. Then measure their heart rate and oxygen levels using the pulse oximeter and breathlessness using the BORG scale.

**Modified Borg scale – Kendrick et al<sup>23</sup>**

0	No breathlessness at all
0.5	Very, very slight (just noticeable)
1	Very slight
2	Slight breathlessness
3	Moderate
4	Somewhat severe
5	Severe breathlessness
6	
7	Very severe breathlessness
8	
9	Very, very severe (almost maximal)
10	Maximal

	At rest	At the end of the test
<b>Oxygen saturations</b>		
<b>Heart rate</b>		
<b>Breathlessness using the Borg Scale</b>		

Total number of sit to stands completed: \_\_\_\_\_

- Attach patient profile with medical history, vaccination status, up to date medication list, relevant letters from other specialists or services.
- Has the patient also been referred to other services including private? If so please list the services or providers to assist with collating relevant clinical information prior to their appointment. Attaching the information would expedite the triaging process.

**Referrer Name:**

Provider number:

Signature:

Date of referral:

Practice email of referrer email (secure) to send correspondence