

# 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)	
Name: _____	MSP Number: _____
Phone: _____ Fax: _____	Email: _____
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: _____
<b>Alternate contact - Name:</b> _____	Phone: _____
	Relationship to patient: _____
<b>Is a translator required?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, language: _____	
CLINICAL INFORMATION	
Date of symptom onset: (dd/mmm/yyyy) _____ <span style="color: red;">* Referrals will only be accepted 3 months after symptom onset.</span>	
Does patient have a positive COVID-19 test? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: (dd/mmm/yyyy) _____	
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 * Required field. - will be used for triage purposes	
<b>Category A</b>	<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 and attach relevant documents) <input type="checkbox"/> cardio <input type="checkbox"/> neuro <input type="checkbox"/> resp <input type="checkbox"/> renal <input type="checkbox"/> musculoskeletal
<b>Category B</b>	<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
<b>Category C</b>	<input type="checkbox"/> Unexplained, persistent symptoms for more than 12 weeks related to presumed or confirmed COVID-19 infection. <input type="checkbox"/> fatigue <input type="checkbox"/> brain fog <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> headaches <input type="checkbox"/> other: _____ <span style="float: right;">(please list)</span>
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) <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any other relevant diagnoses/information: _____	

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

Place Patient Form 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. (See clinical workup checklist)
- Provide your patient with the PHSA website for self-care resources: [www.phsa.ca/postCOVID](http://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://www.phsa.ca/PostCovid>

**FOR GENERAL INQUIRIES VISIT:** [www.phsa.ca/postCOVID](http://www.phsa.ca/postCOVID)

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