Rehabilitative Care Alliance

Hospital Logo

Post COVID-19 Condition Outpatient Rehabilitation Referral Form For Primary Care

Referrals will only be accepted from **physicians or nurse practitioners** for:

- Individuals confirmed to have been COVID-19 positive (NAAT or serology or nasal PCR or Rapid Antigen Test or by using Symptom Based Diagnostic Algorithm*) OR individuals who were symptomatic between January-May 2020 but did NOT have access to a COVID-19 test.
  *See bottom of web page for the algorithm
  AND
- On-going or recurring symptoms that interfere with functioning in activities of daily living or ability to work, continue for more than four weeks and can be attributed to COVID-19 infection (not a pre-existing condition)
  AND
- Basic differential workup has been started to rule out other potential aetiologies as appropriate for symptoms (e.g. chest imaging or blood work)
  AND
- Rehabilitation support is not being received elsewhere for these concerns.
- Patient must be aware of and consent to this referral, and to attend appointments.
- Patient must be medically stable. This referral is NOT for cases requiring urgent care.

Where to send referrals:
Referrals should be sent directly to the organization and program where service is being requested.
For information on COVID-19 Outpatient Rehab Programs, please see https://rehabcareontario.ca/47/COVID-19_Outpatient_Rehabilitation_Programs/ on the Rehabilitative Care Alliance's rehab portal, RehabCareOntario.ca.

NOTE: This referral will be triaged to the most appropriate team members based on information received.

If you require further support or have questions regarding your post-COVID patient, please contact:

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PATIENT AND REFERRAL INFORMATION

PATIENT'S NAME:

_____ *Last name* _____ *First name*

DOB: _____-_____-_____ *yyyy mm dd*

DATE OF REFERRAL: _____-_____-_____ *yyyy mm dd*

HEALTH CARD NUMBER _____

Version Code _____

GENDER: _____ *M/F/Other or Unknown*

HOME ADDRESS / TELEPHONE / EMAIL

_____ *# and Street*

_____ *City* _____ *Postal Code*

Home Tel: _____-_____-_____ Alternate Tel: _____-_____-_____

Email Address _____

Email if patient consents to use? ◯ Yes ◯ No

CONTACTING PATIENT

Contact patient directly for appointment? ◯ Yes ◯ No

If no, Alternate Contact: _____

Relationship to patient: _____

LANGUAGE

Speaks, understands English ◯ Yes ◯ Minimal ◯ No

If Minimal/No, is family interpreter available? ◯ Yes ◯ No

If no, for which language is interpreter needed? _____

Is there a WSIB claim related to the COVID-19 diagnosis?

◯ No ◯ Yes If yes, Claim#: _____

REFERRAL SOURCE:

Name: _____

Specialty: Family MD ◯ Yes ◯ No

If no, specify specialty: Other: _____

Tel: (_____)_____-_____ Fax: (_____)_____-_____

Billing #: _____

Signature: _____

COVID-19 SPECIFIC DATA

Date of symptom onset: _____-_____-_____ *yyyy-mm- dd*

Date of 1st positive COVID-19 test (if applicable): _____-_____-_____*yyyy-mm- dd*

Patient admitted to hospital: ◯ No ◯ Yes

If yes: Date of admission: _____-_____-_____ *yyyy-mm-dd*

Date of discharge: _____-_____-_____ *yyyy-mm-dd*

ICU admission: ◯ No ◯ Yes (Duration: _____days)

Intubation: ◯ No ◯ Yes (Duration: _____days)

Hypoxemic? ◯ No ◯ Yes If oxygen needed/amount _____L/min

Ongoing O2 needed? ◯ No ◯ Yes (_____L/min)

RELEVANT MEDICAL HISTORY / OTHER LONG TERM CONDITIONS

- ☐ COPD and/or asthma
- ☐ Sleep Apnea
- ☐ Hx MI and/or CVA
- ☐ Depression and/or anxiety
- ☐ Renal failure
- ☐ Malignancy (specify location & type) _____
- ☐ Chronic pain condition (specify regional pain syndrome, spinal stenosis) _____
- ☐ Other (specify) _____

ISSUES FOR REHAB TO ADDRESS

- ☐ Self-care
- ☐ Activity Tolerance (walking, exercise)
- ☐ Cognitive symptoms / Brain fog
- ☐ Breathing techniques
- ☐ Fatigue
- ☐ Changes in mood
- ☐ Other (specify below) _____

PLEASE INCLUDE THE FOLLOWING WITH THIS FORM:

☐ Most recent treatment consultation notes ☐ Medication List