



Attach Patient Label Here

POST-COVID-19 RECOVERY CLINIC REFERRAL



* 8 5 6 5 *

Referral Other

Referral Date: _____

NOTE: Referrals will only be accepted for **confirmed** COVID Positive patients or Official Epi-Linked Cases (refer to BCCDC). 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.

This referral will be triaged (see below). We will inform patients of any scheduled appointments. For specific wait times, please refer to Pathways. 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: _____		
Patient's preferred clinic site: <input type="checkbox"/> SPH <input type="checkbox"/> VGH <input type="checkbox"/> FHA		
CLINICAL INFORMATION		
Date of symptom onset: (dd/mmm/yyyy) _____		
Date of first positive COVID-19 test: (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 (this will be used for Triage purposes)		
Category A <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	Category 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	Category C <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 and Clinic Contact Information on reverse.

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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 chosen clinic. Clinic contact information below.

POST-COVID CLINICAL CARE NETWORK REFERRAL CRITERIA:

- Patient is confirmed COVID-19 positive or is Epi-Linked (BCCDC criteria)
- Patient is made aware and consents to attend appointment and investigations

POST COVID-19 CLINIC SITES:

St. Paul's Hospital

Vancouver General Hospital

Surrey - Jim Pattison Outpatient Care and Surgery Centre

CONTACT INFORMATION

PROVIDENCE HEALTH CARE

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

Fax completed referral to: 604-806-9057

Clinic phone: 604-806-8037

For general inquiries: covidrecoveryclinic@providencehealth.bc.ca

For referral forms or other clinic information: <http://www.providencehealthcare.org/covidrecoveryclinic>

VANCOUVER COASTAL HEALTH

Vancouver General Hospital Post-COVID-19 Recovery Clinic

Fax completed referral to: 604-875-5906

FRASER HEALTH

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

Fax completed referral to: 604-528-5440