Providence HEALTH CARE | Vancouver CoastalHealth | fraserhealth | Provincial Health Services Authority

Attach Patient Label Here

POST-COVID-19 RECOVERY CLINIC REFERRAL

Referral Other

Referral Date: ______________________

∗ Required fields must be completed or Referral will NOT be processed.

NOTE: Referrals will only be accepted for:

- **Confirmed** COVID positive (NAAT or serology) or Official Epi-Linked cases.
- Individuals who were symptomatic January - May 2020 and did **NOT** have access to a COVID-19 test.

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. We will inform patients of any scheduled appointments. 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: ☐ Male ☐ Female

Patient address: ______________________ ☐ Other: ________

City / Town: ______________________ Postal Code: ______________________

Patient phone number: ______________________ Email: ______________________

Alternate contact - Name: ______________________ Phone: ______________________

Relationship to patient: ______________________

Patient's preferred clinic site: ☐ SPH ☐ VGH ☐ FHA

Is a translator required? ☐ No ☐ Yes If YES, language: ______________________

CLINICAL INFORMATION

Date of symptom onset: (dd/mmm/yyyy) ______________________ *∗ Required field*

Date of first positive COVID-19 test: (dd/mmm/yyyy) ______________________ *∗ Required field*

Patient admitted to hospital: ☐ No ☐ Yes Date of hospital discharge: (dd/mmm/yyyy) ______________________

ICU admission: ☐ No ☐ Yes Date admitted to ICU: (dd/mmm/yyyy) ______________________

REASON FOR REFERRAL *∗ Required field - will be used for triage purposes*

Category A	Category B	Category C
☐ Hospitalization for COVID-19 ☐ 2 or more ER presentations following diagnosis of COVID-19 ☐ New evidence of end organ impairment without identifiable cause: (check all that apply) ☐ cardio ☐ neuro ☐ resp ☐ renal ☐ musculoskeletal	☐ NYHA dyspnea scale 3 or higher (new finding) ☐ Inability to return to work or school post diagnosis of COVID-19 for 12 or more weeks ☐ Functional deterioration post diagnosis of COVID-19 (dependence on ADLs or iADLs) for 12 or more weeks	☐ 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 (NAAT or serology) or is Epi-Linked (BCCDC criteria)
- Patient was symptomatic January-May 2020 and did not have access to a COVID-19 test
- Patient is made aware and consents to attend appointment and investigations

FOR GENERAL INQUIRIES VISIT: http://www.phsa.ca/our-services/programs-services/post-covid-19-recovery-clinics

OR EMAIL: post-COVID-ICCN@phsa.ca

POST COVID-19 CLINIC SITES:

St. Paul's Hospital
Vancouver General Hospital
Surrey - Jim Pattison Outpatient Care and Surgery Centre
Abbotsford Regional Hospital

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

VANCOUVER COASTAL HEALTH

Vancouver General Hospital Post-COVID-19 Recovery Clinic

Fax completed referral to: 604-873-3471

Clinic phone: 604-675-3688

FRASER HEALTH

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

Fax completed referral to: 604-528-5440

ABBOTSFORD - Abbotsford Regional Hospital Post-COVID-19 Recovery Clinic

Fax completed referral: 604-851-4774

Clinic phone: 1-604-851-4700 local: 642900