

## POST-COVID RECOVERY CLINIC (PCRC) REFERRAL



Referral Other

**Referral Date:** \_\_\_\_\_

*Fields must be completed, or referral will NOT be processed.*

Referrals to the Post-COVID Recovery Clinic (PCRC) are for patients experiencing persistent symptoms affecting daily living for more than 3 months following a presumed or confirmed COVID-19 illness. Note: a positive COVID test is not required.

The clinic can also support patients with conditions that have symptoms similar to long COVID (e.g., brain fog, debilitating fatigue). These conditions include Myalgic Encephalomyelitis/chronic Fatigue Syndrome (ME/CFS), Symptoms Attributed to Lyme Disease (SALD), and Fibromyalgia. Other causes for symptoms must be ruled out (diagnosis of exclusion) prior to referral. Please see page 3 for additional referral guidelines.

PCRC's model of care focuses on self-management of symptoms and patient education, led by allied health professionals including physiotherapists, occupational therapists, social workers, a psychologist and spiritual health practitioner. There is physician support by general internal medicine physicians at the clinic. These physicians also support the RACE line.

Note: The clinic does not offer medical workups, pharmacological care, or referrals to other specialists. The clinic does not complete disability or insurance paperwork for patients.

### REFERRING CLINICIAN

Name: \_\_\_\_\_ MSP Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**FAMILY PHYSICIAN NAME:** (if different from referring clinician) \_\_\_\_\_ MSP Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### PATIENT INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

PHN: \_\_\_\_\_ DOB: (dd/mmm/yyyy) \_\_\_\_\_

Gender:  Male  Female  Non-binary  Other: \_\_\_\_\_  Prefer not to answer

Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

Email: \_\_\_\_\_ Permission to contact patient by email:  Yes  No

**Alternate contact:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### REASON FOR REFERRAL

Tentative Diagnosis: Date of symptom onset (dd/mmm/yyyy): \_\_\_\_\_

Long COVID: Number of COVID-19 Infections  One  Two  Three  Four times or more  unsure

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS)

Symptoms Associated with Lyme Disease (SALD)

Fibromyalgia

Other (specify): \_\_\_\_\_

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REFERRAL**



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Place Patient Label Here

Reason for Referral Continued:

Please check off the following presentations:

| Presentation(s)                              | This condition(s) has been ruled out. | Patient has this condition(s) but it is managed and therefore not the driver for the current clinical presentation. |
|--|---------------------------------------|---|
| <b>Cardiovascular</b>                        |                                       |   |
| Coronary Artery Disease (CAD)                | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Cardiovascular disease                       | <input type="checkbox"/>              | <input type="checkbox"/>  |
| <b>Respiratory</b>                           |                                       |   |
| Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Asthma                                       | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Sleep apnea                                  | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Obstructive sleep, disordered breathing      | <input type="checkbox"/>              | <input type="checkbox"/>  |
| <b>Mental Health</b>                         |                                       |   |
| Depression                                   | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Anxiety                                      | <input type="checkbox"/>              | <input type="checkbox"/>  |
| <b>Other</b>                                 |                                       |   |
| Hypothyroidism                               | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Anemia                                       | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Menopause                                    | <input type="checkbox"/>              | <input type="checkbox"/>  |
| Malignancies                                 | <input type="checkbox"/>              | <input type="checkbox"/>  |

**CLINICAL INFORMATION**

Height: \_\_\_\_\_  inches  cm      Weight: \_\_\_\_\_  lb  kg

**Medication(s)**

| Name of Medication | Dosage (e.g. 10 mg) | Frequency (e.g. once per day) | Taken since (mmm/yyyy) |
|--------------------|---------------------|-------------------------------|------------------------|
|                    |                     |                               |                        |
|                    |                     |                               |                        |
|                    |                     |                               |                        |
|                    |                     |                               |                        |
|                    |                     |                               |                        |

Is there any additional information you would like to share with the clinic team:

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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.
- Provide your patient with the link to [MyGuide Long COVID \(https://www.longcovidguide.ca\)](https://www.longcovidguide.ca), for self-management resources.

### POST-COVID RECOVERY CLINIC (PCRC) GUIDELINES

- You only need to refer your patient to the Post-COVID Recovery Clinic once. We recognize that symptoms of long COVID and other similar conditions can wax and wane depending on if an individual is re-infected with COVID or if they have other co-morbidities. Once they have been referred to the clinic, they do not need to be re-referred if their symptoms resurface as long as there has been no other change in their recent medical history.
- Physicians and nurse practitioners can access the [RACE line](#) for consultations about their patients presenting with long COVID symptoms 604-696-2131 (local RACE line number) or 1-877-696-2131 (toll free) or (<http://www.raceconnect.ca/race-app>)
- Guidelines for treating people living with long COVID can be found on the [Canadian Guidelines for Post COVID-19 Condition](https://canpcc.ca/home) website (<https://canpcc.ca/home>)
- Patients can access [MyGuide Long COVID](https://www.longcovidguide.ca) website (<https://www.longcovidguide.ca>), an online tool designed to help patients and their primary caregivers find the best practice information so they can self-manage long COVID symptoms at any time from any device.

**FOR GENERAL INQUIRIES VISIT:** <https://www.longcovidguide.ca> **OR EMAIL:** [post-COVID-ICCN@phsa.ca](mailto:post-COVID-ICCN@phsa.ca)

**Fax completed referral to 604-806-8809**