**Post COVID Virtual MDT Referral Form**

Access to the Virtual MDT is for patients believed to have post COVID syndrome and who require further clinical assessment and investigations following initial investigations by the GP and local Paediatrician. Patient access to this pathway should be irrespective of previous positive SARS-Cov-2 serology.

Where there is not a clinical need for a patient to access the Virtual MDT, the local paediatricians may determine a patient may need to be referred directly for rehabilitation or follow-on services. Local routes for referral should be used in this instance in alignment with local implementation plans. **Referrals should be sent to** [**london.cyppostcovid@nhs.net**](mailto:london.cyppostcovid@nhs.net)

|  |  |
| --- | --- |
| **Patient Information** | |
| **Patient Details** | |
| **First name** |  |
| **Surname** |  |
| **D.O.B** |  |
| **NHS number** |  |
| **Gender/Transgender identifier** |  |
| **Patient Address (postcode)** |  |
| **Ethnicity** |  |
| **Preferred choice of communication** |  |
| **School (including Home Schooled)** |  |
| **Next of Kin Name and Contact Details** |  |
| **Does the individual use alternative or augmented communication? Is an interpreter required?:** |  |
| **Additional Supporting Information** | |
| **Height** |  |
| **Weight** |  |
| **Other professionals involved in the care of the patient:** |  |
| **Psychosocial concerns:** |  |
| **Safeguarding concerns:** |  |
| **Co-morbidities** | |
| **Allergies** |  |
| **Current Medication** |  |
| **Physical and Mental co-morbidities:** |  |
| **Neurodevelopmental condition(s):** |  |
| **Pre-existing mental health condition(s)** |  |

**Inclusion Criteria**

The referral template contains the inclusion and exclusion criteria that should be considered by the paediatrician (via the paediatrician-led triage) as part of determining a child/young persons suitability for referral to the Virtual MDT.

**Exclusion Criteria: Any known underlying physical and mental health issues that better explains symptoms (unless there has been a change in symptoms since contracting COVID-19)**

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| --- | --- | --- | --- | --- |
| **Requirement** | **Inclusion Criteria** | | | **Response** |
| **Essential** | Is the individual aged up to 18/aged 18 in school/college or other secondary education? | | | Y/N |
| **Essential** | Has the individual experienced symptoms for more than three months. Individuals can be considered under three months if other causes have been excluded (as per the NICE definition.) | | | Y/N |
| **Not essential** | Does the individual have a history of suspected Covid-19 infection with one of the three criteria below | | |  |
| 1. **Previous PCR positive for SARS-CoV-2** | | | Y/N |
| 1. **COVID antibody positivity** | | | Y/N |
| 1. **Clear close epidemiological link to be determined on a case by case basis (school/family etc)** | | | Y/N |
| **Date of previous positive COVID-19 swab (if performed)** | | |  |
| **Essential (one or more)** | **Does the individual have one or more of the following as a predominant symptom? Please detail.** | | |  |
| (i) Severe fatigue that is preventing ADLs – e.g. going to school /activities/nursery/ play dates/ regression | | |  |
| (ii) Change from baseline that is unacceptable to referring Dr/Pt | | |  |
| (iii) Temporally associated persistent unexplained physical symptoms | | |  |
| **Essential (one or more)** | **Is the individual experiencing one or more of the following:** | | |  |
| Fatigue | Abdominal pain | Anxiety or low mood |  |
| Respiratory | Brain Fog | Headaches |
| Pain |  |  |
| Other | | |
| **Essential** | Can the individual symptoms be explained by another condition? | | |  |
| **Essential** | Does the individual have a history of PIMS-TS *(N.B. these patients will already have follow-up but should not be excluded from the clinic)* | | |  |
| **Essential** | Have screening bloods been done? | | | *Please list those that have been done and the results* |
| **Essential** | What other investigations have been conducted? | | | *Please list those that have been done and the results* |
| **Essential** | Result of 6 minute walk and Sit/stand assessment | | |  |
| **Essential** | Has the patient and/or parent/carer been given/completed the ISARIC questionnaire? | | |  |

**N.B. Even if a patient does not meet the criteria, they may still be discussed with a paediatrician to consider referral to the assessment clinic, depending on clinical judgement**

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