**Post COVID Virtual MDT Referral Form**

Access to the Virtual MDT is for local paediatrician (or in some cases GP where there is no available paediatrician) bring patients believed to have post COVID syndrome for discussion/ advice or referral for further clinical assessment and investigations. 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 paediatrician 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**

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|  **Patient Information**  |
| **Patient Details** |
| **First name** |  |
| **Surname** |  |
| **D.O.B** |  |
| **NHS number** |  |
| **Gender/Transgender identifier** |  |
| **Patient Address (postcode)** |  |
| **Contact Email** |  |
| **Contact Telephone Number** |  |
| **Ethnicity** |  |
| **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:** |  |
| **Family history** |  |
| **Medical Information** |
| **Allergies** |  |
| **Current Medication** |  |
| **Physical and Mental co-morbidities:** |  |
| **Neurodevelopmental condition(s):** |  |
| **Pre-existing medical or mental health condition(s)** |  |
| **Educational concerns** |  |
| **Referrer Information** |
| **Referrer name and job title** |  |
| **Hospital** |  |
| **Date of referral** |  |

**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 person’s 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 years (or 18 years 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 |
| **Essential** | Date of presumed COVID |  |
| Date of onset of symptoms |  |
| **Not essential** | **Does the individual have a history of suspected Covid-19 infection with one of the three criteria below *(please include dates)*** |  |
| 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) Symptoms that are preventing ADLs – e.g. going to school /activities/nursery/ play dates/ regression | Please explain |
| (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:**  | Please give brief history of symptoms below |
| Fatigue | Abdominal symptoms | Anxiety or low mood |  |
| Respiratory symptoms | Brain Fog | Headaches |
| Pain |  |  |
| Other |
| **Essential** | Can the individual symptoms be explained by another condition? | Y/N |
| **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?**FBC, Blood film, U+E, LFT, Bone, Coeliac screen, CK, TFT, ESR, CRP, random blood glucose, ferritin, ANA, SARS-CoV-2 serology, vitamin D, vitamin B12, iron studies, EBV and CMV serology and PCR. | *Please list the results* |
| **Essential** | **What other investigations have been conducted?**Additional investigations based on clinical judgement* Troponin, D-Dimers and VWF/ADAMTS
* Faecal calprotectin (if abdominal symptoms)
* Urine dip and albumin/creatinine ratio
* ECG (if palpitations, breathlessness etc)
* cardiac ECHO only following MDT discussion
* Imaging as appropriate (e.g CXR, abdominal USS)
 | *Please list those that have been done and the results* |
| **Essential** | Result of sit/stand (if done) or 6 minute walk |  |
| **Essential** | Please ensure the patient and/or carer has completed the ISARIC questionnaire and attach with this referral. |  |
| **Further Information** | Medications tried: |  |
| Self-Management tools: |  |
| Other professional input: |  |
| Specific question(s) for the virtual MDT: |  |

**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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