SHN
SCARBOROUGH HEALTH NETWORK

Patient Label

Long COVID-19 Service - Acute Medicine

*Please **fax this referral & any relevant information to 416-495-2420.** Patient will be contacted for an appointment.*

300178

Date: _____

Referring Physician: _____ CPSO#: _____

Primary Care Provider: _____

Patient to be seen within: ☐ Urgent ☐ 7 days ☐ 14 Days

Date of COVID-19 Diagnosis: _____

Hospital admission due to COVID-19: ☐Yes ☐No **ICU stay:** ☐Yes ☐No **Length of Stay:** _____

Intubated: ☐ Yes (Duration: _____ days) ☐ No

Optiflow: ☐ Yes (Duration: _____ days) ☐ No

Past Medical/Surgical/Mental Health History:

_____

_____

_____

Current Medications: *(or attach list)*

_____

_____

Drug Allergies/Sensitivities:

_____

Reason for referral: Respiratory Symptoms ☐ Mood Related Symptoms ☐ Musculoskeletal Symptoms ☐ Other ☐

Please describe symptoms in further detail.

_____

_____

_____

Patient's Goals:

_____

_____

Referral completed by: _____ **Phone #:** _____

(Please print name)

Distribution: Chart