

Bar Code
(For ICCS use only)



Surname

First Name

Permanent Address

Postal Code

Cell Phone

Home Phone

Work Phone

Date of Birth

Age

HCN#

Expiry Date

Integrated Chronic Care Service Post COVID Service Referral

The Integrated Chronic Care Service (ICCS) is an interdisciplinary clinic that provides comprehensive assessment, treatment, and care planning for individuals with symptoms consistent with a Post-COVID syndrome. ICCS offers a holistic, whole person approach guided by the *patient's self-identified functional goals and readiness to make lifestyle changes*.

We are a consultation-based service and do **not** provide primary care. The Post COVID service is a time-limited pathway that requires ongoing collaboration with the referring primary care provider. Referrals will only be accepted for patients that have had a confirmed COVID positive result (PCR or rapid) or individuals with suspected COVID and have persistent symptoms (>12 weeks post positive test or symptom onset) impeding the patients ADLs and iADLs.

Note: This service is **not** for patients with active COVID or those requiring **urgent** care for COVID or post-COVID sequelae. If you are questioning your patient's medical stability (e.g. pulmonary embolism a possibility, unstable vital signs), the post-COVID service is **not** an appropriate initial place to have these concerns addressed. You should discuss your concerns with an internist and/or refer the patient for emergent/urgent care. The post-COVID service is for medically stable patients suffering from a post-COVID syndrome.

REFERRING PRIMARY CARE PROVIDER

Name: _____
Phone: _____ Fax: _____
Address: _____

CLINICAL INFORMATION

Date of symptom onset or date of first positive COVID-19 test: _____
Patient admitted to hospital Y/N: _____ Date of hospital discharge: _____
Patient admitted to ICU: Y/N: _____ Date admitted to ICU: _____
Presenting complaints (check all that apply):
☐ persistent cough
☐ shortness of breath
☐ low grade fever
☐ fatigue
☐ chest pain
☐ headache
☐ neurocognitive difficulty ("brain fog")
☐ muscle pain and weakness – sites of weakness _____
☐ gastrointestinal upset
☐ rashes otherwise unexplained (vesicular, maculopapular, urticarial, or chilblain-like lesions)
☐ metabolic disruption (i.e. poor control of diabetes)

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- ☐ thromboembolic conditions
- ☐ depression/ anxiety
- ☐ other mental health conditions
- ☐ other, please explain:

Other relevant diagnosis and health concerns (mental health, diabetes, cardiac conditions, respiratory conditions)

REFERRING PROVIDER CHECK LIST

- ☐ Patient previously COVID-19 positive or suspected of having COVID-19
 - ☐ Patient **does not** have active COVID or require urgent COVID intervention
 - ☐ Patient presents with function impairments (>12 weeks post COVID positive test or symptom onset) in ADLs and/ or iADLs
 - ☐ Patient consents to ICCS Post COVID service including attending appointments, investigations, participating in group intervention, and is aware this service is time-limited (max x months)
 - ☐ Do you feel patient has the supports to manage their symptoms?
 - ☐ Patient presenting symptoms are not otherwise explained, thus suspected post COVID
 - ☐ Include pertinent lab reports, diagnostic imaging, consultations, medical notes with referral
- Required
- **If you patient is experiencing shortness of breath:** CXR, spirometry, possible EKG
 - **Bloodwork:** basic metabolic panel (electrolytes, renal function, glucose), magnesium, calcium, albumin, CBC, CRP

Please forward this referral and other relevant documentation to:

Integrated Chronic Care Service
3064 Highway 2
Fall River, NS, Canada, B2T 1J5
Phone: (902) 860-0057
Fax: (902) 860-2046

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Category: _____ Reviewed by: _____ Date: _____

Medical Intake: _____

Additional Notes: _____