PROVIDENCE
UNITY HEALTH TORONTO

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Providence Healthcare Admissions Office
3276 St. Clair Ave. E. Toronto, ON M1L 1W1
Tel: (416) 285-3744
Fax: (416) 285-3759

Referral Date: _____

Outpatient Post-COVID Condition Rehabilitation Program Referral

Referrals will only be accepted from **physicians or nurse practitioners** for:

- Individuals confirmed to have been COVID-19 positive (NAAT or serology or nasal PCR or Rapid Antigen Test or by symptom-based clinical diagnosis), OR individuals who were symptomatic between January-May 2020 but did not have access to a COVID-19 test.
- Patient must be aware of and consent to this referral, and to attend appointments and investigations.
- Patient must be medically stable and past the acute phase of COVID-19 illness (8-12 weeks). This referral is NOT for cases requiring urgent care.

NOTE: This referral will be triaged to the most appropriate services based on information received (see page 3 for program description). We will contact patients directly to arrange appointments. If you require further support or have questions regarding your post-COVID patient, please request advice from the Admissions Office at (416) 285-3744.

PATIENT INFORMATION	**ALTERNATE CONTACT**
Name of Patient: _____, _____ *(Last Name)* *(First Name)*	Name:
	Relationship to Patient:
Age:	Telephone: ( ) -
Date of Birth:	**FAMILY PHYSICIAN**
Health Card #: Version Code:	Name:
Address: _____, _____, _____, _____ *(# and street)* *(City)* *(Prov.)* *(Postal Code)*	Telephone: ( ) - Fax: ( ) -
Telephone: ( ) -	☐ Family MD is the same as referral source
Email address:	**COVID-19 SPECIFIC DATA**
Contact patient directly for appointment? ◯ YES ◯ NO	Date of Symptom Onset:
Is an interpreter required? ◯ YES (Language: _____) ◯ NO	Date of 1st positive COVID-19 test (if applicable):
Relevant Medical History:	Patient admitted to hospital? ◯ YES ◯ NO If yes: Date of admission: _____ Date of discharge: _____
	ICU admission: ◯ YES (Duration: ____ days) ◯ NO Intubation: ◯ YES (Duration: ____ days) ◯ NO
	Does the patient currently require supplemental oxygen? ◯ YES (____ L/min) ◯ NO
REHABILITATION GOALS AND CONCERNS:	**REFERRAL INFORMATION**
	Referring Physician: _____ *(If not family physician)* *(Name and Specialty, if applicable)*
	Organization:
	Telephone: (____) ____-_____ Fax: (____) ____-_____
	Billing #:
Please include with this form: ☐ Consultation/discharge notes (e.g. OT, PT, SLP, SW, MD, etc.) ☐ Medication List ☐ Post COVID Symptom Checklist (Appendix A)	Signature:

Date of Completion:

Patient Name:_____
Birthdate:_____

Appendix A: Post COVID Symptom Checklist

Sample Script: The next part of the survey we will be discussing any symptoms you are currently experiencing as a result of COVID-19. The symptoms are divided into categories which will help us determine how to best direct your recovery. If you have no symptoms in a category, please indicate N/A and we will move on to the next section. If you are unsure, we will ask more detailed questions. For each question, please indicate if your symptoms are **worse**, the **same** or **better** than before your illness.

Cardiorespiratory Symptoms? ☒ Yes ☐ N/A ☐ Unsure	
Shortness of breath at rest? ☐ N/A	☐ Worse ☐ Same ☐ Better
Shortness of breath with activity? ☐ N/A	☐ Worse ☐ Same ☐ Better
Lingering cough or noisy breathing? ☐ N/A	☐ Worse ☐ Same ☐ Better
Chest pain at rest? ☐ N/A	☐ Worse ☐ Same ☐ Better
Chest pain with activity? ☐ N/A	☐ Worse ☐ Same ☐ Better
Dizziness, fainting or loss of consciousness? ☐ N/A	☐ Worse ☐ Same ☐ Better

Musculoskeletal Symptoms? ☐ Yes ☐ N/A ☐ Unsure	
Generalized muscle weakness? ☐ N/A	☐ Worse ☐ Same ☐ Better
Muscle or joint pain? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty walking? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty doing own washing & dressing? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty doing your usual activities (i.e. leisure or work)? ☐ N/A	☐ Worse ☐ Same ☐ Better

Mood Related Symptoms? ☐ Yes ☐ N/A ☐ Unsure	
Experiencing anxiety? ☐ N/A	☐ Worse ☐ Same ☐ Better
Experiencing depression? ☐ N/A	☐ Worse ☐ Same ☐ Better

Neurological Symptoms? ☐ Yes ☐ N/A ☐ Unsure	
Difficulty controlling the movement of your body? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty eating, drinking or swallowing (i.e. uncoordinated, slow, painful, choking, coughing)? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty speaking (e.g. voice changes, formulating explanations, etc.)? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty controlling your: Bowels? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty controlling your: Bladder? ☐ N/A	☐ Worse ☐ Same ☐ Better
Issues with concentration, thinking or memory? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty hearing? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty seeing? ☐ N/A	☐ Worse ☐ Same ☐ Better

Other Symptoms? ☐ Yes ☐ N/A ☐ Unsure	
Extreme fatigue/exhaustion? ☐ N/A Worse after physical or mental activity?	☐ Worse ☐ Same ☐ Better ☐Yes ☐ No
Have you lost your taste or sense of smell?	☐Yes ☐ No
Have you been eating less than usual for more than 1 week?	☐Yes ☐ No
Have you lost or gained a significant amount of weight without trying?	☐Yes ☐ No ☐Lost ☐ Gained
Issues with pain or discomfort? ☐ N/A	☐ Worse ☐ Same ☐ Better
Difficulty sleeping? ☐ N/A	☐ Worse ☐ Same ☐ Better
Headaches? ☐ N/A	☐ Worse ☐ Same ☐ Better

***See Additional Question below**

* Upon completion, providers should ask clients about additional symptoms that may have been missed.

***Additional Question:** Are you experiencing any stomach, digestion, or bowel concerns? ☐Yes ☐ No

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Who we serve:

You have been referred to our program by your physician, who has identified that you are experiencing symptoms consistent with Post-COVID-19 Condition (persistent symptoms 2-3 months after acute infection). After COVID-19 illness, it is common for individuals to experience a variety of ongoing medical, physical and psychological effects. These may include decreased energy, altered thinking skills, speech and swallowing issues, changes in mood, difficulty coping, and other concerns. The combination of these effects can make it difficult to return to one's usual daily activities.

What we do:

The Post COVID-19 Condition Outpatient Rehabilitation Program offers a therapeutic education program and support to individuals experiencing functional loss (difficulty with activities of daily living) due to post-COVID-19 condition. The focus of the program is teaching you how to manage your ongoing symptoms and maximize your independence and function.

The foundation of our program is comprised of a Therapeutic Education Series and Peer Support Group. These are delivered by our inter-disciplinary team, and address a variety of topics relevant to Post-COVID-19 Condition. Our team includes the following clinicians: Physiatrist, Occupational Therapist, Physiotherapist, Speech Language Pathologist, Social Worker, Dietician, and Community Health Navigator.

Our intake process will determine whether any additional consultations are required in addition to participation in Therapeutic Education and Peer Support Groups.

You may also be connected with other external specialists/services as needed.

What you should expect:

- Our clinic will contact you to offer you the next available spot for our Virtual Therapeutic Education Series.
- You will be asked to complete a comprehensive Intake Questionnaire to help our team better understand your needs and goals
- Any recommendations and referrals suggested by our team will be communicated with you and summarized in a letter to your family physician when you complete the program.

About Virtual Rehabilitation:

Virtual rehabilitation is the use of technology to allow you and our team to connect via secure video or telephone. We are working very hard to ensure that you will receive high quality care, however we appreciate your patience if there are challenges along the way, as virtual care is a relatively new way of delivering health services.

Barriers to engaging in virtual care will be considered on an individual basis at the time of intake and service delivery adapted accordingly.

Your privacy is important. Our Virtual Rehabilitation uses a secure platform called Zoom. This platform ensures the privacy and security of your personal health information at all times.