COVID-19 Recovery Clinic Referral Form

Date of Referral: ____

Patient demographics (or affix label):

Name:

DOB/Age: PHN:

Phone number:

Address:

COVID-19 testing: ☐ Confirmed ☐ Presumed

COVID-19 positive test date: (dd/mmm/yyyy) _____________________

Tobacco use: ☐ Current ☐ Ex-smoker ☐ Never

Patient admitted to hospital: ☐ Yes ☐ No

Date of hospital discharge: (dd/mmm/yyyy) ______________________

ICU admission: ☐ Yes ☐ No

Date admitted to ICU: (dd/mmm/yyyy) __________________________

Please list all symptoms, duration and any treatments tried to date:

Please attach the patient's medical history and current medication list:

Referring physician information (or stamp):

Name & PRAC ID:

Clinic name & address:

Clinic phone & fax:

Member of which PCN?:

Please fax your referral to 780.473.7181