Government of South Australia
SA Health

Southern Adelaide Local Health Network

LONG COVID REHABILITATION CLINIC REFERRAL FORM

(MR666)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

PLEASE FAX TO: (08) 8404 2263

4th Generation Clinics

PATIENT DETAILS:	**DATE OF REFERRAL:** __ __ / __ __ / 2 0 __ __
Surname:	Date of Birth: __ __ / __ __ / __ __ __ __ Gender: ☐ Male ☐ Female
Given Name(s):	Telephone:
Address:	Mobile:
	Medicare Number:
Postal Address: (*if different to above*)	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Interpreter / Language: ☐ Yes ☐ No If yes, details	Compensable:
	DVA number:
GP DETAILS:	
Name	Contact
SUBSTITUTE DECISION MAKER/PERSON RESPONSIBLE/NEXT OF KIN	
Name.....	Relationship .....
Contact No	Patient consent to referral: ☐ Yes ☐ No

Please only tick ONE box below

REFERRAL TO		
☐ Dr Kisani Manuel	☐ Dr Hong Mei Khor	☐ Dr Subbuh Luker

CLINIC ACCEPTANCE CRITERIA
• Confirmed indirection on testing e.g. PCR, RAT
• Persistent and significant symptoms at least 6 weeks
• RED FLAGS (DO NOT refer to this clinic. Refer for emergency management):
– Severe, new onset or worsening dyspnoea or hypoxia
– Syncope
– Unexplained chest pain, palpitations or arrythmias where appropriate investigations have not been undertaken
– New delirium or focal neurological signs
– Severe psychiatric symptoms
Date of confirmed infection with a positive COVID-19 test __ __ / __ __ / 2 0 __ __

REFERRAL INFORMATION
Reason for Referral:

Form has dual purpose—Scan as
Referral **Out** –**Sending Referrer** Service
Referral **In** – (select Speciality) –**Receiving** Service/Clinic

LONG COVID REHABILITATION CLINIC REFERRAL FORM MR666

SALHN

May 2025

Please use black ballpoint pen when completing this form

Government of South Australia
SA Health

Southern Adelaide Local Health Network

LONG COVID REHABILITATION CLINIC REFERRAL FORM

(MR#)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

SYMPTOMS AND LABORATORY INVESTIGATIONS

Attach the following results to the referral: CBE, EUC, LFTs, then symptom specific

Indicate the symptoms present:

Symptoms	Present	If yes, investigation to be conducted and results attached
Fatigue with no alternative case	☐ YES ☐ NO	☐ Bloods: Iron Studies, vitamin B12, thyroid function
Shortness of breath with no alternative case	☐ YES ☐ NO	☐ D-dimer ☐ Chest Xray if not contraindicated ☐ CTPA or VA scan as clinically appropriate ☐ Spirometry (handheld) if available or PFTS if done ☐ Echocardiogram as appropriate
Muscle/joint pain with no alternative case	☐ YES ☐ NO	☐ Bloods: ESR, CRP
Headaches with no alternative case	☐ YES ☐ NO	☐ Bloods: ESR, CRP ☐ Cerebral imaging as appropriate
Cognitive signs with no alternative case	☐ YES ☐ NO	☐ Bloods: Vitamin B12 Studies, Thyroid function ☐ Cerebral imaging as appropriate
Functional decline	☐ YES ☐ NO	
Mental Health conditions	☐ YES ☐ NO	
Gastrointestinal symptoms with no alternative case	☐ YES ☐ NO	☐ ESR, CRP, antibody testing for coeliac disease
Sleep disturbance	☐ YES ☐ NO	
Palpitations	☐ YES ☐ NO	☐ ESR, TFTs, Holter
Chest pain: PE and ischaemic heart disease ruled out	☐ YES ☐ NO	☐ If no cardiovascular risk factors present: CXR, ECG, Echocardiogram ☐ If cardiovascular risk factors present managed in lie with national guidelines
Orthostatic intolerance/POTS-like symptoms/suspected POTS	☐ YES ☐ NO	☐ ECG, Echo, Holter, TFTs, Iron Studies, 10-minute lean test, d-dimer, CPR, ESR, tropoinin
Other Symptoms	☐ YES ☐ NO	

☐ Attached patient profile with medical history, vaccination status, up to date medication list, relevant letters from other specialists services.

☐ Has the patient also been referred to other services including private? If so please list the services or providers to assist with collating relevant clinical information prior to their appointment. Attaching the information would expedite the triaging process.

REFERRER COMPLETING THIS FORM

Full Name *(Please Print)*	Designation *(Please Print)*	
Signature	Date __ __ / __ __ / 2 0 __ __	Time ____ ____ : ____ ____ AM PM
Date of referral: __ __ / __ __ / 2 0 __ __	Referring Unit:	Provider no.:
Referral Period: ☐ 12 months ☐ Indefinite	Referring Consultant:	
Tel:	Fax:	

Please phone (08) 8404 2269 if any queries regarding referrals

Please use black ballpoint pen when completing this form