**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| First name |  | Surname |  |
| D.O.B. |  | Phone |  |
| Address |  | NHS No: |  |
|  | GP Surgery Name: |  |

**Referring Clinician**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Contact Number |  |
| Source | GP [ ]   | Acute Resp.Team |  [ ]  |
|  | Hot Hub [ ]  | Paramedics |  [ ]  |
|  | 111 [ ]  | Maternity Services |  [ ]  |

**Please note that for referrals from SECONDARY CARE, an attachment with most recent blood test is required to ensure patient receives the right treatment.**

**Criteria for Referral**

|  |
| --- |
| **For consideration of nMAB or anti-viral treatment** |
| COVID PCR Positive **AND** 18 years or older **AND** extremely clinically vulnerable and has been informed may be eligible for nMAB/Anti-virals (symptom-onset within the last 5 days) - tick box to confirm [ ] Aged 85 years and over [ ] End-stage heart failure who have a long-term ventricular assistance device [ ] On the organ transplant waiting list [ ] People aged 70 years and over or who have a BMI of 35kg/m2 or more, diabetes or heart failure and are resident in a care home [ ] Date of Positive LFT/PCR Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Onset of Symptoms (if =>5days from onset, do not refer unless significant clinical concern): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(If consideration for nMABs is the reason for referral, no need to complete rest of form)  |
|  |

|  |
| --- |
| **For consideration of monitoring only**  **Please ensure that RESPECT forms are reviewed, and hospital admission would be acceptable if required, otherwise not appropriate for monitoring only service.** |
| COVID Positive and 65 years or over [ ]  |
| COVID Positive and clinically vulnerable but not eligible for nMAB / anti-virals [ ]   |
| Acute Respiratory Infection (any cause) requiring daily monitoring (aged 18 and over) [ ]  |
| Day of Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Significant PMH (Please include baseline saturation if known chronic respiratory disease) |  |
| BP |  |
| PR |  |

|  |  |
| --- | --- |
| O2 sats in air |  |
| RR |  |
| Temp |  |
| GCS |  |
| Regular Medications |  |
| Allergies |  |
| Does the patient have social support whilst isolating? | Yes/No |
| Does the patient need a translator? | If yes what language |
| Please confirm that you have provided the patient with a Pulse Oximeter/Information Pack | Yes/No |

Email the completed form to: **crgpa.respiratoryathome@nhs.net**.

To contact the Virtual Ward Admin Team please email **crgpa.respiratoryathome@nhs.net** or call **07881 359254**.