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|  | | **COVID Care in the Community Referral** | | | Surname: First Name: Address:  Phone No(s): DOB: | | MRN  Gender: |
| *Covid Care in the Community is an outpatient service.*  *Referrals will not be accepted unless the below Referral Form is completed, ensuring your referral meets the eligibility criteria outlined and forward to email* [*MNCLHD-CCICReferrals@health.nsw.gov.au.*](mailto:MNCLHD-CCICReferrals@health.nsw.gov.au) *with REFERRAL in the subject line.*  *We will prioritise & triage referrals based on high clinical need that cannot be self-managed or managed by their GP.*  *If your patient has a SERIOUS Medical CONCERN - Please CALL NSW Ambulance 000, please inform them that they are COVID-19 Positive. If they present to the Emergency by private car, please ensure they wear a mask and inform staff of COVID-19 status. For non-urgent clinical advice and support, care should be managed by the GP in the first instance.*  *For further advice support is available via*   * *NSW COVID Care at Home Support Line on 1800 960 933.* * *Health Direct 1800 022 222.* * *Mental Health Access Line phone 1800 011 511.* * [After Hours GP Helpline - Healthy North Coast (hnc.org.au)](https://hnc.org.au/after-hours-gp-helpline/) *Phone 1800 931 158* | | | | | | | |
| COVID Status |  | | | | | | Results pending – DO NOT refer until COVID status confirmed |
| Date of test |  | | Symptom onset date: | | | |  |
| COVID  Vaccination Status | Vaccination Status:  Booster Status:  Date of last dose: | | | | | |  |
| Age – Risk considerations | Under 1 month  or over 50 if unvaccinated | | | Aged over 80 | |  | Babies under 1 month are considered High Risk & eligible for referral |
| Cultural | Identifies as Aboriginal | | | Torres Strait Islander | |  | If cultural support required: consider pts usual supports/ AMS |
| Has one or more of the following symptoms | Persistent fever  >39 C Haemoptysis  Dyspnoeic at rest  Chest pain – sustained with dyspnoea  Diarrhoea with less then 50% fluid intake  Persistent Vomiting with less than 50% fluid intake  Fainting or Collapsing | | | Extra Details: | | | Proceed with referral if patient meets identified one or more listed risk factors:   1. Age Risk Considerations 2. Aged over 50 & unvaccinated with symptoms 3. Symptoms 4. Significant Medical history 5. Social 6. Pregnancy criteria     If patient does not meet above  DO NOT proceed with referral.  Patient to continue on self- managed pathway  or  GP Managed Pathway |
| Significant Medical History | * Cardiac (severe heart failure) * Respiratory   Severe asthma COPD Other  BiPAP CPAP Home Oxygen  Poorly controlled diabetes  Chronic Kidney Disease with eGFR less than 45  Cancer (recent chemo/radiotherapy)  Organ transplant  Immunocompromised  Immunodeficiency  > 20mg prednisolone daily  Morbid Obesity  Severe Global Neurological Disability | | | Details: | | |
| Pregnant | Weeks’ Gestation: | | | **Pregnancy:** Ensure notification ALSO to MNCLHD ante-natal service of any pregnant persons COVID status: [MNCLHD-MCCT@he](mailto:MNCLHD-MCCT@health.nsw.gov.au)alth.nsw.gov.au | | | |
| Social Risk Factors | Nil Carer / Family to provide supports  Disability without appropriate supports  Cultural Supports | | | Outline Request / Details of current services: | | | |
| Referral Requests | * Monoclonal antibody treatment * Review of very high risk symptomatic patient for monitoring * Extreme hardship. | | | Details: | | | |
| Medications | List: | | | | | | Ongoing / regular medications – GP  to attend scripts |
| Referrer Name:  Return correspondence details: MANDATORY  Email: | | | | Designation:  Phone: | |  | |

Choose an item.