**Referral for consideration of treatment for Covid-19 infection**

***Referral data to accompany referral***

**Version 2 – 11 February 2022**

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| **SECTION 1: PATIENT DETAILS** | |
| **Name** |  |
| **Address** |  |
| **Eircode** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Telephone number** |  |

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| **SECTION 2: SYMPTOMS AND TESTING** |  |
| **Symptom onset** date  Any of *fever, chills, sore throat, cough, shortness of breath or difficulty breathing, nausea, vomiting, diarrhoea, headache, red or watery eyes, body aches, loss of taste or smell, fatigue, loss of appetite, confusion, dizziness, pressure or tight chest, chest pain, stomach ache, rash, sneezing, sputum or phlegm, runny nose, other* |  |
| **Positive PCR** sample date *(if known)* |  |

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| **SECTION 4: REASON FOR SEVERE IMMUNOCOMPROMISE and/or HIGH RISK CONDITION(S)** |
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| **SECTION 3. INDICATION FOR REFERRAL (select one)** |

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| Severely immunocompromised *(indicate reason severely immunocompromised in box below)* |  |
| Has not completed primary vaccine course **and** 65 years or older |  |
| Has not completed primary vaccine course **and** 64 years or younger  **and** with high risk condition  *(indicate high risk condition in box below)* |  |

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| **SECTION 5: If the patient is under the care of a Hospital Consultant for these conditions, please indicate the Consultant here.** |
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| **SECTION 6: OTHER RELEVANT PAST MEDICAL HISTORY** |
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| **SECTION 7: MEDICATION** |
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| **SECTION 8: ALLERGIES** |
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| **SECTION 8: REFERRER** |  |
| **Name of referrer** |  |
| **Contact details** |  |
| **Date and time referred** |  |