



**COVID Recovery Clinic
New Patient Referral Form**

Clinic Staff Use Only
UNC Patient Label

The UNC COVID Recovery Clinic (CRC) provides consultative care for persons with Post-COVID Conditions (Long COVID). Eligibility criteria include:

- Positive COVID test (must be documented within referring provider’s documentation)
- Post-COVID symptoms lasting at least 2 months
- Patient must be age 18+

Referring provider, please note requirements of new patient referrals:

- The patient listed above meets the above-listed criteria.
- The CRC will provide an initial consultation with generally no more than 2 follow-up evaluations. Long term care will be provided by the patient’s existing care team.
- The CRC will provide management recommendations which can be implemented by the patient’s existing providers, such as the primary care provider or specialist.
- Completion of disability or employer paperwork is the responsibility of the patient’s existing care team. The CRC will be unable to complete.

Patient Information	
Patient Name	Date of Birth ____ / ____ / ____
Type of COVID + Test (check) <input type="checkbox"/> NAAT (PCR) <input type="checkbox"/> Nucleocapsid Ab <input type="checkbox"/> Antigen <input type="checkbox"/> Home Test	Date of COVID + Test ____ / ____ / ____
What are symptoms of concern as they relate to the referral? (check)	
<input type="checkbox"/> Fatigue <input type="checkbox"/> Dyspnea <input type="checkbox"/> Chest pain <input type="checkbox"/> Cognitive symptoms (“brain fog”) <input type="checkbox"/> Autonomic instability <input type="checkbox"/> Smell or taste disturbance	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Difficulty with walking <input type="checkbox"/> Impaired self-care (ADLs) <input type="checkbox"/> Inability to work <input type="checkbox"/> Other: _____
Referring Provider Information	
Referring Provider Name	Referring Practice Name
Referring Practice Phone	Referring Practice Fax
Name of Person Completing Form	Signature of Person Completing Form
	Date: _____ Time: _____

Please provide this referral form, a patient face sheet, and a current H&P, including all current medications, recent labs, and imaging studies, to the UNC COVID Recovery Clinic by Fax # 984-215-2643.

