CULLMAN REGIONAL | Medical Group

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POST-COVID CONDITIONS CLINIC REFERRAL FORM

Patient name _____ DOB _____

Address _____ Alternate contact name _____

City/State/Zip _____ Alternate phone _____

Telephone _____ Relationship _____

Language/Ethnicity _____ ☐ Male ☐ Female

Primary Care Physician (PCP) _____ Telephone _____

Primary Insurance _____ ☐ Medicare ☐ Medicaid ☐ Commercial ☐ PPO

Contract # _____ Telephone _____

Physician _____

Physician signature _____ Date _____ Time _____

Please include most recent notes and face sheet.

CLINICAL INFORMATION

Month and year of first positive COVID-19 test: _____

Patient admitted to hospital: ☐ Yes ☐ No

Patient symptoms (please check all that apply):

GENERAL ISSUES
- ☐ Progression of chronic issues/conditions
- ☐ Impaired daily function and mobility
- ☐ Weakness
- ☐ Fatigue
- ☐ Dizziness or lightheadedness

PAIN SYNDROMES
- ☐ Ongoing pain related to COVID-19 diagnosis or treatment
- ☐ Myalgias
- ☐ Neuropathy

RESPIRATORY ISSUES
- ☐ Dyspnea
- ☐ Cough
- ☐ Pain with inspiration
- ☐ Exercise intolerance

NEUROLOGICAL ISSUES
- ☐ Brain Fog
- ☐ Memory loss

PSYCHOLOGICAL ISSUES
- ☐ PTSD
- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression

Call 256-735-5646 to schedule an appointment.