Post-COVID CARE Clinic
THE QUEEN'S HEALTH SYSTEM

Provider Referral Form

THE QUEEN'S HEALTH SYSTEMS POST-COVID CARE CLINIC ELIGIBILITY CRITERIA

- ☐ Patient must be at least 30 to 45 days post COVID infection with persistent COVID symptoms.
- ☐ Patient must be at least 15 years of age.
- ☐ QEC accepts most insurances EXCEPT the following: Medicare HMO, Commercial HMO, Kaiser Health Plans, No Fault, Senior Medical Group (SMG), Tricare Prime, or Workers' Compensation.
- ☐ ***PATIENT MUST BE REFERRED BY CURRENT PRIMARY CARE PROVIDER (PCP); REFERRALS FROM PROVIDERS WHO ARE NOT THE PATIENT'S PCP WILL NOT BE PROCESSED.***

IN ORDER TO ENSURE THAT THE REFERRAL IS PROCESSED PLEASE NOTE:

- ☐ Patient must have a confirmed positive COVID-19 infection diagnosis AND a copy of test results ATTACHED to referral. If home test was used for diagnosis- documentation of home test results MUST be in an office visit note.
- ☐ REFERRAL MUST be accompanied by demographics sheet, most recent labs, and most current office visit notes.

REASON FOR REFERRAL (PLEASE SELECT AT LEAST TWO; ICD-10 MUST BE DOCUMENTED IN ACCOMPANYING OFFICE VISIT NOTES):

- ☐ Covid 19 (U09.9 or U07.1)
- ☐ Dyspnea (R06.0) or Dyspnea on exertion (R06.09)
- ☐ Fatigue (R53.82 or R53.83)
- ☐ Cognitive impairment or "brain fog" (G31.84 or R41.89/.9)
- ☐ Headache (R51) or Cluster Headache (G44.019)
- ☐ Arthralgia (M25.50)
- ☐ Myalgia (M79.12) or Chronic fatigue & malaise (R53.81/.82)
- ☐ Lightheadedness or Dizziness (R42)
- ☐ Reduced or impaired mobility (Z74 or Z74.09)
- ☐ Impaired daily function or problems related to life management difficulties (Z73)
- ☐ Anosmia (R43.0)
- ☐ Dysgeusia (R43.8)
- ☐ Other (please describe and provide ICD-10 code):

_____

_____

PATIENT CONTACT INFORMATION

Name _____ DOB _____

Address _____

Phone Number _____

Email _____ Preferred Language _____

Insurance Provider _____ Member ID _____

Date of Positive COVID-19 Test _____ Testing Site _____

REFERRING PHYSICIAN: _____

REFERRING PCP CONTACT INFORMATION AND SIGNATURE:

Name _____

Address _____

Phone # _____ Fax # _____

Signature _____ Date _____

REFERRAL IS VALID FOR 6 MONTHS FROM DATE OF SIGNATURE.
Please fax this form with a COVER Sheet, labs, and provider notes to (808) 691-4614.
Complete referral packets will be processed AND patient will be contacted for scheduling using the contact information provided above. Incomplete referral packets WILL NOT be processed. If you have any questions, please feel free to call us at (808) 691-4970.

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