UCLA Health

Long COVID PROGRAM

Physician Referral Request Form
Fax Request to 310-825-2631

Referrals

- **Must** include PCR/lab results confirming the patient's positive COVID history
- We **cannot** accept home tests (**No exceptions allowed**).
- If the referred patient only has an at-home test, please have the patient complete a Nucleocapsid test to determine eligibility (refer below).
- After a referral is reviewed and it is determined that the referred patient has met the eligibility criteria, we will reach out to the patient via e-mail, as each patient must complete our Long COVID packet before scheduling an initial visit.
- The patient will be scheduled to see an internal medicine specialist to confirm a Long COVID diagnosis.

Please know that once enrolled in the program, **the Long COVID Internist will NOT BECOME A PATIENT'S PRIMARY CARE PHYSICIAN**.

REFERRING	REFERRING PHYSICIAN:	
	Office Contact:	
	Fax: Phone:	
PCP (IF DIFFERENT FROM REFERRING)	Physician Name:	
	Office Contact:	
	Fax:	
	Phone:	
PATIENT'S INFORMATION	LAST NAME:	FIRST NAME:
	DOB:	UCLA MRN (if available):
	Phone:	E-mail:
INSURANCE	INSURANCE:	HMO☐ PPO☐ MEDICARE☐ OTHER☐
	Medi Cal: HMO☐ Straight☐	Medi-Cal Insurance Plan:

COVID-19 History

Does the patient have a documented covid-19 test?	YES☐ , Date tested:_____ (copy of the patient's positive COVID Test/LAB REPORT must be attached to the referral for evaluation)

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If so, is the patient at least 12 weeks from their initial COVID-19 diagnosis?	NO☐ Other☐ _____	
If the patient does not have a copy of a positive COVID test, they must complete a Nucleocapsid blood test to determine eligibility. (please refer to the attached ordering details)	Quest Diagnostics Lab Test Name: SARS-CoV-2 Antibody (IgG), Nucleocapsid, Qualitative Test Code:39749 DX: Z86.16	LabCorp Test Name: SARS-CoV-2 Antibody, Nucleocapsid Test Code: 164068 DX: Z86.16

LONG COVID SYMPTOMS	☐Fatigue ☐Loss of taste and/or smell ☐Chest pain or tightness ☐Palpitations ☐Cough ☐Dyspnea	☐Brain fog ☐Insomnia ☐Anxiety ☐Depression ☐Other: _____
DOCUMENTS ATTACHED *PLEASE ATTACH ANY RELEVANT MEDICAL RECORDS/ TESTING IF AVAILABLE (PLEASE INCLUDE PHQ-9 AND GAD-7)	☐ H&P (notes MUST indicate when the referred patient first had symptoms) ☐Hospital Records (Admission and D/C report IF available)	Imaging/ Tests: Tests completed since COVID Diagnosis only ☐ Labs ☐ Autonomic reflex screen ☐ Sleep study ☐ Pulmonary Function Tests ☐ Chest CT ☐ Chest X-rays ☐ MRIs ☐ ECHO ☐Stress Test ☐Ziopatch/Holter