ICU 12 WEEK COVID FOLLOW-UP CLINIC MEDICAL ASSESSMENT

Patient Name		DOB	
Age		H&C no	
Clinic date		ICU location	

Date, Team Members & Family Present

How patient has been feeling/managing since 6 week review

Issues flagged at 6 week review & interim actions

Enquire if need any further explanation about their ICU stay, or any further questions they may have.

INVESTIGATIONS

Latest FBP/Date	Hb	MCV	Plt	WCC	Ferritin

Latest U&E/Date	Na	K	Urea	Creat	eGFR	BNP

CXR Date & Report

PFTs Date & Report

Echocardiogram Date & Report

Other Investigations & Report

Ongoing /outstanding Review Appointments/Investigations

ECG to be done at clinic

12 WEEK CLINIC ASSESSMENT – CURRENT SYMPTOMS

Ask patients how they have been, how close to their usual health do they feel? As a % Have they had any healthcare interactions since discharge, explain detailed systematic questions

Cardio/respiratory	
mMRC Dyspnoea Scale /4	
Cough	
Dysphonia/change voice	
Chest pain/tightness	
Orthopnea/peripheral oedema	

CNS/PNS	
Fatigue	
Limb weakness	
Myalgia	
Sensory disturbance/numbness	
Memory/confusion	
Hearing	
Vision	
Anosmia/loss of taste	
Pain	
Change in balance	

GI/Nutrition	
Glycaemic control	
Swallowing	
Appetite/anorexia	
Change in bowel habit	
Weight loss/gain	

Other	
On-going IHD	
Urinary symptoms	
Erectile dysfunction	
Periods normal	
Recent infections	
Pressure sores	
Line sites	
Skin/hair changes	
PSQI score	

Are any symptoms out of keeping with expected recovery? Concerning? Or distressing?

12 WEEK CLINC ASSESSMENT - FUNCTION

Function	
ET - METS	
Current CFS	
Assistance for ADLs	
Marital status/who at home	
Return to work	
Finances	
Return to driving	
Leisure/sport	
Social interaction	
Family	

Alcohol units/week		Assess need for referral to addiction team
Recreational drugs		Assess need for referral to addiction team

Smoking/day		Advise on cessation, self refer to GP

Ask patient what are the main issues concerning them at the moment

SpO2 at rest/examination as necessary

Ask patient if can update other team members on their progress/wish to visit ICU

12 WEEK CLINIC ASSESSMENT – FAMILY INPUT, SUMMARY & PLAN

Family experience of ICU admission and current issues

Summary of assessment

Guidance for on-going management;

1. Symptoms improving as expected for a patient following severe viral pneumonia with no evidence abnormal CXR and/or physiological impairment ➔ discharge from medical follow up. (Other MDT members can arrange follow up as required e.g physiotherapy)
2. Sputum for O&S if productive cough +/- infective symptoms (pyrexia, malaise, sweats, anorexia)
3. Evidence abnormal CXR and/or physiological impairment (abnormal PFTs; raised NT-ProBNP; symptoms out of keeping with resolving pneumonia) patients should get further investigations based on suspected diagnosis
    a. HRCT (? Covid-related ILD)
    b. SPECT VQ (?CTED/CTEPH)
    c. Echocardiogram (mark urgent)
    d. All patients who have had PE diagnosed at any part of their Covid journey should get a VQ and urgent echo organised at 12 weeks.
4. Then refer all of these patients to Dr…… for appropriate follow up (will divide ILD cases amongst respiratory physicians and follow up CTED/CTEPH at Pulmonary Vascular Disease clinic).
5. Refer non-respiratory problems to the relevant specialist – please see list of specialists on Teams.

Referrals to Other Specialties/Investigations	Reason	Request Completed

COMPLETED BY:

PHYSIOTHERAPY ASSESSMENT – COMPLETED BY & DATE:

GENERAL AX

RESP SYSTEM	CV
NEURO	MSK
OTHER: Consent given for future research YES/ NO Consent given for exercise class YES/NO	

PHYSIOTHERAPY OUTCOME MEASURES

Can patient get from lying to standing unaided?

EQ-5D-5L

60Second Sit Stand Result NUMBER: SCORE:		
HR	SpO_2	Borg

DASI	
Total Score	METS

Functional Status Tool

Consider walk test with assessment of oxygen saturation

Advice given/Referrals

CLINICAL PSYCHOLOGY ASSESSMENT – COMPLETED BY & Date:

PHQ9 & GAD-7

PCL-5

General assessment

Psychological	
Mood/concentration	
Memories of ICU	
Sleep/dreams/night mares	
Hallucinations/strange thoughts	
Additional stressors	

Advice given/Referrals

12 WEEK PHARMACY ASSESSMENT – MEDICATION REVIEW & OUTSTANDING INVESTIGATIONS

Current Medications
Medicines reconciliation sources (circle each source used) ECR / patient / medicines / chemist / discharge letter / GP / other

New medications during admission	Still required/Plan

Pre-admission medications not yet restarted	Required?/Plan

No. of medicines	Regular	Prn
Pre-ICU		
ICU discharge		
Hospital discharge		

Medication related intervention required? Y / N If Y document in table below

Intervention category	Detail
Clarification of dose omissions	
Drug dose adjustment	
Duration review	
New drug recommendation	
Patient education	
Adverse drug reaction	
Review of ineffective drug prescribing	
Adherence problem identified	

Completed by: Date:

12 WEEK DIETICIAN REVIEW

Pre-illness weight: **Current Weight:** **Height:** **BMI:** **Weight loss as inpatient:** **Weight aim:** **Diabetes:**	
Summary of previous dietetic assessment if available:	
Abnormal Biochemistry:	
Relevant Medical issues:	
Nutritional issues – bowels / skin / taste changes / nausea / appetite / exercise /energy levels	
Nutrition review:	
Nutritional requirements (if applicable):	**Justifications:**
Energy	
Protein	
PLAN: Review: Completed by Dietitian reg number & date:	

12 WEEK SPEECH & LANGUAGE REVIEW
Date & Completed by:

General assessment

Voice Handicap Index (VHI -10)

Dyspaghia assessment