**Post Covid-19 Rehabilitation Hub**

**Telephone/On-line Screening pro forma**

Name: **Click here to enter text.** DOB: **Click here to enter text.**

NHS Number **Click here to enter text.** Date of screening: **Click here to enter text.**

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| **Dimension** | **Question and Outcome** |
|  | We want to know what matters to you in relation to your recovery and would like you to respond to the following questions to help identify your further needs. |
| 1. Household/  social situation | **Do you live alone?**  Choose an item.  **Do you receive support/ help from others with your usual routines?**  Choose an item.  **Do you live in a care home?**  Choose an item.  **Do you have access to on-line/ computer technology?**  Choose an item.  **Do you have a private phone number?**  Choose an item. |
| 2. EQ-5D-5L  **Mobility** | **This question is about Mobility**   |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | I have no problems in walking about | 1 | 1 | | I have slight problems in walking about | 2 | 2 | | I have moderate problems in walking about | 3 | 3 | | I have severe problems in walking about | 4 | 4 | | I am unable to walk about | 5 | 5 |   Click here to enter text. |
| EQ-5D-5L  **Self-Care** | **This question is about Self Care**   |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | I have no problems washing or dressing myself | 1 | 1 | | I have slight problems washing or dressing myself | 2 | 2 | | I have moderate problems washing or dressing myself | 3 | 3 | | I have severe problems washing or dressing myself | 4 | 4 | | I am unable to wash or dress myself | 5 | 5 |   Click here to enter text. |
| EQ-5D-5L  **Usual**  **Activities** | **This question is about Usual Activities**  *(e.g. work, study, housework, family or leisure activities)*   |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | I have no problems doing my usual activities | 1 | 1 | | I have slight problems doing my usual activities | 2 | 2 | | I have moderate problems doing my usual activities | 3 | 3 | | I have severe problems doing my usual activities | 4 | 4 | | I am unable to do my usual activities | 5 | 5 |   Click here to enter text. |

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| EQ-5D-5L  **Pain/**  **Discomfort** | **This question is about Pain/Discomfort**   |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | I have no pain or discomfort | 1 | 1 | | I have slight pain or discomfort | 2 | 2 | | I have moderate pain or discomfort | 3 | 3 | | I have severe pain or discomfort | 4 | 4 | | I have extreme pain or discomfort | 5 | 5 |   Click here to enter text. |
| EQ-5D-5L  **Anxiety/**  **Depression** | **This question is about Anxiety / Depression**   |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | I am not anxious or depressed | 1 | 1 | | I am slightly anxious or depressed | 2 | 2 | | I am moderately anxious or depressed | 3 | 3 | | I am severely anxious or depressed | 4 | 4 | | I am extremely anxious or depressed | 5 | 5 |   Click here to enter text. |
|  | |  |  |  | | --- | --- | --- | |  | **Pre-Covid** | **Now** | | **TOTAL** | Click here to enter text. | Click here to enter text. | | **Difference** | Click here to enter text. | | |
| EQ-5D-5L  **Perceived**  **Health** | **We would like to know how good or bad your health is TODAY.**   * This scale is numbered from 0 to 100 * 100 means the best health you can imagine * 0 means the worst health you can imagine   What is the score pre Covid and what is the number today?   |  |  | | --- | --- | | **Pre-Covid** | Click here to enter text./100 | | **Today** | Click here to enter text./100 | | **Difference (+/-)** | Click here to enter text./100 | |
| **URGENT PSYCHOLOGICAL RESPONSE** | **Have you or are you planning to hurt yourself?**  Choose an item.  **If yes refer please speak to your GP for support.**  **The MIND website**  [www.mind.org.uk/information-support/coronavirus/](http://www.mind.org.uk/information-support/coronavirus/)  **The Samaritans are available on 0114 276 7277** |

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| 3. | **If answer yes to any question please rate and refer to the Hub** |
|  | **Are you anxious about your breathing?**  Choose an item.  **Are you getting any of the following fast heartbeat, stomach churning, sweatiness, dizziness?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item.  **Are you getting upsetting thoughts, memories or dreams linked to the time you were unwell?**  Choose an item.  **Are you having greater difficulty falling or staying asleep?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item. |
| 4. | **If answer yes to any question please rate and refer to the Hub** |
| **Participation** | **Does your health prevent you from going back to your usual pre – Covid day to day activities including work (if appropriate) or hobbies?**  **(subject to lockdown restrictions)**  Choose an item.  **Is fatigue or extreme tiredness an ongoing issue for you?**  Choose an item.  **Do you feel isolated ?**  Choose an item.  **Are you lonely?**  Choose an item. |
| **Activities** | **Are you feeling distractible and finding it more difficult to concentrate?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item.  **Are you struggling to plan and organise yourself?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item.  **Are you having problems with your memory?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item. |

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| 5. | **If answer yes to any question please rate and refer to the Hub** |
| **Cognitive -Communication** | **Have you or your family noticed any change in the way you communicate with people, such as making sense of things people say to you, putting thoughts or feelings into words, difficulty reading or having a conversation?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0-5**  Choose an item. |
| **Voice** | **Have you or your family noticed any changes to your voice such as difficulty being heard, altered quality of the voice, your voice tiring by the end of the day or an inability to alter the pitch of your voice?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0 - 5**  Choose an item. |
| **Laryngeal/**  **airway complications** | **Have you developed any changes in the sensitivity of your throat such as troublesome cough or noisy breathing?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0-5**  Choose an item. |
| **Swallowing** | **Are you having difficulties eating, drinking or swallowing such as coughing, choking or avoiding any food or drinks?**  Choose an item.  **If Yes: rate the significance of impact on a scale of 0-5**  Choose an item. |
| 6. | **If answer yes to any question please rate and refer to the Hub** |
| **Diet/nutrition** | **Are you or your family concerned that you may be underweight or need nutritional advice?**  Choose an item.  **Have you recently lost a lot of weight unintentionally?**  Choose an item.  **Have you noticed that your clothes or rings have become loose recently**  Choose an item.  **Have you recently lost your appetite and/or interest in eating?**  Choose an item. |
| 7. | **If answer yes to any question please rate and refer to the Hub** |
| **Breathing** | **Are you struggling with shortness of breath or altered breathing pattern following your illness?**  Choose an item. |
| **Secretions** | **Are you still coughing anything up (since having Covid-19?)**  Choose an item. |
| **Falls** | **Have you started having falls since being unwell with COVID?**  Choose an item.  **Are you afraid of falling?**  Choose an item. |
| **Physical Activity** | **Have your physical activity levels returned to your usual levels following Covid 19 infection?**  Choose an item.  **Can you do what you want to be able to do in terms of your physical activity/ exercise levels compared to before you had Covid?**  Choose an item. |
| 8. | **If answer yes to any question please rate and refer to the Hub** |
| **Symptom management** | **Are you already being seen by a hospital medical specialist?**  Choose an item.  **What is this related to?**  Click here to enter text.  **Are you experiencing any new symptoms such as**  **Dizziness** Choose an item.  **Chest pain** Choose an item.  **Shortness of breath** Choose an item.  **Uncontrolled pain** Choose an item.  **Are you experiencing trouble taking your medications appropriately since your illness?**  Choose an item.  **Do you find any of your skin is sore from sitting for long periods ?**  Choose an item.  **Have you experienced problems with continence following discharge home ?**  Choose an item. |
| 9. | **Referral** |
|  | **Would you like to continue to receive assessment and treatment for your needs**?  Choose an item.  **We would like to share information with the Sheffield Post Covid Rehabilitation Hub, is that alright?**  Choose an item.  **Is there anything else important to you to mention, that we haven't covered?**  Choose an item.  Click here to enter text. |