MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Department of Physical Medicine & Rehabilitation
325 E. Eisenhower Parkway, Ann Arbor, MI 48108
Phone: 734-936-7052
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Dear Valued Partner,

Thank you for referring your patient to the Michigan Medicine Adult Post-COVID Clinic. This clinic is staffed by specialists in Physical Medicine and Rehabilitation.

Our program is centered around a six-session Post-COVID Recovery Group. This group was developed by our team of rehabilitation psychology and neuropsychology providers to equip patients with science-based education, skills, and interventions to address their current symptoms and optimize quality of life.

Our Post-COVID Physician Assistant also sees patients to offer consultation and recommendations for the primary care providers or other specialists to consider for ongoing medical management. Patients are offered up to three visits with the PA; some patients may be referred to our Post-COVID physician and/or neuropsychologist depending on symptoms and course of acute COVID-19 infection.

This clinic **does not** replace the care of a specialist or a primary care physician for management of ongoing symptoms. **Referrals to specialists, orders for labs, and disability paperwork completion are out of scope for this clinic.**

What We Need From You

To properly evaluate your patient's referral, please complete the attached form and include the following with your referral documentation:

- New Patient Consultation Request form (attached)
- Documentation of lab-confirmed positive COVID-19 test
- Note from last referring provider visit **and/or** discharge summary from COVID-19 hospitalization
- Reports of any lab studies performed during or after COVID-19 infection
- Reports of any radiological studies performed during or after COVID-19 infection

Who Will Benefit From This Clinic?

- Patients who are having difficulty coping with or managing their ongoing emotional, cognitive, or physical symptoms and are:
    - Looking for self-management techniques and recommendations to improve their quality of life, improve their level of functioning, and resume many of the daily activities that they engaged in pre-COVID

Who Will Not Benefit From This Clinic?

- Patients who are looking for ongoing management of:
    - Moderate-to-severe underlying conditions and comorbidities that contributed to their complicated acute COVID-19 course;
    - Moderate-to-severe new onset physical symptoms brought on by COVID infection that are already being managed by the appropriate specialty, such lung disease managed by a pulmonologist, new onset diabetes managed by an endocrinologist, or inflammation managed by a rheumatologist
- Patients looking for trial or experimental treatments for post-COVID conditions

Thank you, and we look forward to partnering with you in the care of your patient.

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Adult Post-COVID Clinic: New Patient Information Request Form

Date: _____

Referring Physician: _____ Fax Number: _____

Patient Name: _____ DOB:_____

UMHS Registration # (if available): _____ Gender: M F

Telephone: Home (____)_____ Work: (____)_____Other: (____)_____

Address:_____ City:_____ State:_____ Zip:_____

1) It is required that the patient has **documented, lab-confirmed** COVID-19 infection from more than 3 months ago; does this patient meet that criterion? ___ Yes ___ No
Note: *We cannot accept home antigen test results or a positive antibody result as proof of infection.*

2) Did the patient have an acute hospitalization specifically for COVID-19 infection? ___ Yes ___ No
Note: This does not include ED visit, urgent care, or observation, or a hospitalization with incidental COVID-19 finding.
If Yes, you MUST include the discharge summary with this form, as indicated in the cover letter.

3) Primary Symptoms (*check all that apply*):

___ Exertional fatigue ___ Chronic fatigue ___ Shortness of breath/dyspnea
___ Neurologic concerns (dizziness, altered gait, etc) ___ Musculoskeletal or joint pain
___ Spine or back pain ___ Chronic headaches
___ Cognitive concerns (forgetfulness, brain fog, etc) ___ Adjustment or mood disorder

4) Does the patient have a history of psychiatric diagnoses, substance abuse disorder, or psychiatric hospitalization within the last 12 months? ____ Yes ___ No

Please only send relevant documentation pertaining to this referral (see cover letter). If you are including more than 10 pages of medical records, please indicate the page numbers for where the required information can be found so that we can verify that the referral is complete.

Referring Physician Signature: (required for Neuropsychological testing, if appropriate)

_____
(Signature) (Date)