Joined Up Care Derbyshire

Derbyshire Post Covid Syndrome Questionnaire (For patients with ongoing symptoms following Coronavirus)

Patient name and Date of Birth: ____

Date of completion: ____

Breathing	Mobility	Energy levels	Mood
Back to normal ☐	Back to normal ☐	Able to manage all usual activities as normal ☐	My mood and mental ability are basically normal again ☐
Not normal but I can do everything ☐	Nearly back to normal ☐	Feeling tired but managing normal activities ☐	I am OK apart from moments of low mood, anxiety or brief thinking lapses ☐
Breathless on hills/stairs/ walking fast ☐	Having to move more slowly, but doing everything ☐	Feeling tired, needing to rest frequently, restricting normal activities ☐	I suffer most days from low mood or anxiety ☐
Stops me doing some things ☐	Struggling with some activities ☐	Significant tiredness, occasionally unable to participate in normal activities ☐	My memory is now poor and I struggle to think ☐
Breathless on minimal activity ☐	Barely getting around ☐	Significant tireness, unable to participate in normal activities each day ☐	I feel suicidal or I feel hopelessness or I just cannot think or remember at all ☐
Breathless at rest ☐	Bed bound ☐	Fatigue is debilitating and persistent dependent on others for all tasks ☐	I hear voices or I am losing my grip on reality ☐

Please tick the description in each column that best describes how you currently feel so that a Clinician can refer you to the appropriate services for your symptoms

This questionnaire is for people in Derbyshire that have had either a confirmed diagnosis of coronavirus disease (Covid-19) or have experienced coronavirus symptoms, such as a high temperature, persistent cough, loss of taste and smell. This questionnaire is to find out if you are continuing to experience diagnosed coronavirus or suspected coronavirus symptoms. We will add any information you provide in your clinical notes, and forward on to the Post Covid Assessment Clinic, where Clinicians from different professions, for example, physiotherapists, speech and language therapists, dieticians, mental health workers etc, will assess you and will work together to ensure you receive the most appropriate care for your symptoms. You may also be referred to other services to provide additional support and treatment for your symptoms. The information you provide will be stored as per data protection regulations, and used for purposes of clinical assessment only (for use only by Clinicians involved in your care), and will be kept in your patient records.

If there is anything that you do not wish to complete then please feel free to skip that section.

Do you agree to share the information you provide with the Post Covid Syndrome Assessment Clinic today? **Yes** ☐ **No** ☐

What was your health like before you had Covid, some examples are below to assist you: I did not have any restrictions on my life (please comment below)   I had some restrictions, eg mobility (please comment below)   I had existing restrictions on my life (please comment below)
Are you living with a long term health condition(s)? **Yes** ☐ **No** ☐ If yes, please list what long term health condition(s) you have, for example, diabetes, a breathing condition, or a heart related condition. How does this affect you? Please explain below.

Were you admitted to hospital with a diagnosis of Covid, or were you admitted to hospital with Covid like symptoms? **Yes** ☐ **No** ☐
If yes, to the above, have you had any further medical problems? Please explain below.   Have you needed to go back to hospital since your discharge or needed to seek medical help/advice relating to Covid like symptoms? Please explain below.   Were you re-admitted to hospital? **Yes** ☐ **No** ☐ Details:
Have you used any other health services since discharge from hospital for Covid like symptoms (for example, your GP?), If Yes, please explain below. Yes ☐ No ☐

How have you been affected by Coronavirus?	
1. Breathlessness	On a scale of 0-10, with 0 being not breathless at all, and 10 being extremely breathless, how breathless are you: (Answer N/A if you do not perform this activity) a) At rest? Now **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Before Covid **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ b) On dressing yourself? Now **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Before Covid **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ N/A ☐ c) On walking up a flight of stairs? Now **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐

	Before Covid **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ N/A ☐
2. Cardiac (heart related) chest pain (angina)	Do you have symptoms of angina or cardiac chest pain, for example, chest discomfort or shortness of breath? **Yes** ☐ **No** ☐ If yes, is this new (following covid) or old? **New** ☐ **Old** ☐ If yes, how is it affecting you in activities of daily living on the scale of 0-10 below (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
3. Palpitations or feeling of your own heart flutters	Do you have symptoms of heart palpitations/flutters? **Yes** ☐ **No** ☐ If yes, is this new (following covid) or old? **New** ☐ **Old** ☐ If yes, how is it affecting you in activities of daily living on the scale of 0-10 below (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
4. Stroke	Have you had a stroke since having Covid like symptoms? **Yes** ☐ **No** ☐ If yes, has a stroke had an impact on your ability to carry out your normal daily activities? **Yes** ☐ **No** ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
5. Throat/ breathing problems	Have you developed any changes in the sensitivity of your throat such as troublesome cough or noisy breathing? **Yes** ☐ **No** ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
6. Voice	Have you or your family noticed any changes to your voice such as difficulty being heard, changed quality of the voice, your voice tiring by the end of the day or an inability to change the pitch of your voice? **Yes** ☐ **No** ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐

7. Swallowing	Are you having difficulties eating, drinking or swallowing such as coughing, choking or avoiding any food or drinks? **Yes** ☐ **No** ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
8. Nutrition (Eating)	Are you or your family concerned that you have ongoing weight loss or any ongoing nutritional concerns as a result of Covid-19? **Yes** ☐ **No** ☐ Please rank your appetite or interest in eating on a scale of 0-10 since Covid-19 (0 being same as usual/no problems, 10 being very severe problems/reduction) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
9. Mobility (Movement)	On a 0-10 scale, how severe are any problems you have in walking about, for example, taking 50 steps? 0 means you have no problems, 10 means you are completely unable to walk about. Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
10. Fatigue or Exhaustion	Do you become fatigued (extremely tired) more easily compared to before your illness? **Yes** ☐ **No** ☐ If yes, how severely does this affect your mobility (movement), personal care, activities or enjoyment of life? (0 being not affecting, 10 being very severely impacting) Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
11. Personal Care	On a 0-10 scale, how severe are any problems you have in personal care such as washing and dressing yourself? (0 means you have no problems, 10 means you are completely unable to do my personal care) Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
12. Continence (control of bowel or bladder)	Since your illness are you having any new problems with: • controlling your bowel **Yes** ☐ **No** ☐ • controlling your bladder **Yes** ☐ **No** ☐
13. Usual Activities	On a 0-10 scale, how severe are any problems you have in doing your usual activities, such as household chores, leisure activities, work or study? 0 means you have no problems, 10 means you are completely unable to do your usual activities. Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
14. Pain/ discomfort	On a 0-10 scale, how severe is any pain or discomfort you have? 0 means you have no pain or discomfort, 10 means you have extremely severe pain

	Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
15. Cognition (the ability to think, memory, clarity of thought, how we organise ourselves, how we process things)	Since your illness have you had new or worsened difficulty with: • concentrating? **Yes** ☐ **No** ☐ • short term memory? **Yes** ☐ **No** ☐
16. Cognitive-Communication (how our ability to think and organise our thoughts impacts on how we are able to communicate with others both verbally and non-verbally)	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 into words, difficulty reading or having a conversation? **Yes** ☐ **No** ☐ If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
17. Anxiety (feeling worried or nervous)	On a 0-10 scale, how severe is the anxiety you are experiencing? 0 means you are not anxious, 10 means you are extremely anxious. Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
18. Depression (sadness or lack of interest)	On a 0-10 scale, how severe is the depression you are experiencing? 0 means you are not depressed, 10 means you have extreme depression. Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Pre-Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
19. Post Traumatic Stress Disorder (PTSD - an anxiety disorder caused by very	a) Have you had any unwanted memories of your illness or hospital admission whilst you are awake, so not including dreams? **Yes** ☐ **No** ☐ If yes, how much do these memories bother you? (is the distress: **mild** ☐ **/ moderate** ☐ **/ severe** ☐ **/ extreme** ☐) b) Have you had any unpleasant dreams about your illness or hospital admission? **Yes**☐ **No**☐

stressful, frightening or distressing events)	If yes, how much do these dreams bother you? (is the distress: **mild** ☐ **/ moderate** ☐ **/ severe** ☐ **/ extreme** ☐) c) Have you tried to avoid thoughts or feelings about your illness or hospital admission? **Yes** ☐ **No** ☐ If yes, how much effort do you make to avoid these thoughts or feelings? (**mild** ☐ **/ moderate** ☐ **/ severe** ☐ **/ extreme** ☐) d) Are you currently having thoughts about harming yourself in any way? **Yes** ☐ **No** ☐
20. Overall Health	How poor do you feel your overall health is? (10 means the worst health you can imagine. 0 means the best health you can imagine). Now: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ Before Covid: **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐
21. Vocation (employment)	What is your employment situation? Occupation: ____ Has your illness affected your ability to do your usual work? **Yes**☐ **No**☐ Employment status before Covid-19 Lockdown: ______________________________ Employment status before you became ill: __________________________________ Employment status now: ____
22. Family/carers views	Do you think your family or carer would have anything to add from their perspective/view?

Are you experiencing any other new problems since your illness not mentioned above?   Any other discussion (clinical notes):

Joined Up Care
Derbyshire

Covid-19 Follow-up screening tool (for use by Clinician in Post Covid Syndrome Assessment Clinic/Multi-Disciplinary Team)

Patient Name and Date of Birth ____

Date ______________________________________

Breathing	Mobility	Energy levels	Mood
Back to normal ☐	Back to normal ☐	Able to manage all usual activities as normal ☐	My mood and mental ability are basically normal again ☐
Not normal but I can do everything ☐	Nearly back to normal ☐	Feeling tired but managing normal activities ☐	I am OK apart from moments of low mood, anxiety or brief thinking lapses ☐
Breathless on hills/stairs/ walking fast ☐	Having to move more slowly, but doing everything ☐	Feeling tired, needing to rest frequently, restricting normal activities ☐	I suffer most days from low mood <u>or</u> anxiety ☐
Stops me doing some things ☐	Struggling with some activities ☐	Significant tiredness, occasionally unable to participate in normal activities ☐	My memory is now poor and I struggle to think ☐
Breathless on minimal activity ☐	Barely getting around ☐	Significant tireness, unable to participate in normal activities each day ☐	I feel suicidal <u>or</u> I feel hopelessness <u>or</u> I just cannot think or remember at all ☐
Breathless at rest ☐	Bed bound ☐	Fatigue is debilitating and persistent dependent on others for all tasks ☐	I hear voices <u>or</u> I am losing my grip on reality ☐

Please tick the description in each column that best describes how the patient currently feels following conversation with Clinician