Dartmouth Health

Dartmouth Hitchcock Medical Center

Toll Free: (866) 346-2362
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: ______________________ Office Phone: ______________________

Practice Name: ______________________ Fax: ______________________

Practice Address ______________________ PCP Name: ______________________

Patient Name: ______________________ MRN# ______________________

DOB: ____________ Cell Phone ______________ Home Phone ______________ Work Phone ______________

Mailing Address: ______________________

Will a supplied interpreter be needed for this appointment? ❏ No ❏ Yes Language: ______________________

Health Insurance: ______________________ Subscribers Name: ______________________

Policy #: ______________________ Group# ______________________ Subscribers DOB ______________________

Referral for Post-Acute COVID Syndrome (PACS) Clinic

❏ **Please check that you have provided proof of a positive Covid-19 test***

Presenting symptoms/diagnosis (description of acute illness): ______________________

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Required Information:

❏ Patient is ≥18 years old

❏ Positive SARS-CoV-1 PCR or antigen, positive SARS-CoV-2 nucleocapsid antibody, picture of positive home antigen test, or office note describing acute illness

❏ It has been 12+ weeks since acute illness

❏ Pertinent office notes with medications, vital signs, labs (CBC, CMP)

Incomplete or ineligible information on this form will result in a request for additional information which will delay the scheduling of your patient.