Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60404A

Dossier : _____

Nom, Prénom : _____

Date de naissance : _____ ☐F ☐M
aaaa-mm-jj

NAM : *Exp.* _____
aaaa-mm

Nom, Prénom de la mère : _____

SERVICE REQUEST
CO-VIE REHABILITATION SERVICE (LONG COVID)

PATIENT IDENTIFICATION[1]

Fill out all fields in the upper right corner, except the file number if unknown.

Age: Language: ☐French ☐ English ☐ Other: _____

*Patient's address: *Apartment: _____

*City: *Province: *Postal code: _____

*Telephone: Authorization to leave a message: ☐ Yes ☐ No

Other telephone *(specify)*: Authorization to leave a message: ☐ Yes ☐ No

*Email: _____

[1] Mandatory information indicated with an asterisk *

EMERGENCY CONTACT

Person to contact in case of an emergency (name, relationship): _____

Telephone number (emergency contact): _____

HISTORY OF COVID-19

Start date of last COVID-19 infection (yyyy-mm-dd):

Severity of symptoms

☐Asymptomatic

☐Mild symptoms

☐Moderate to severe symptoms

☐Needed hospitalization

☐Intensive care

Change in your condition since the start of the illness

☐Better

☐Stable

☐ Worse

Comments:

Nom : Prénom : #Dossier :

CURRENT POST-COVID-19 SYMPTOMS				
In the past ***4 weeks,*** to what degree have the following symptoms affected your daily life? **0** = *No problem* - I have no symptoms **1** = *Mild problem* - They have little or no effect on my daily life - Not very disruptive **2** = *Moderate problem* - They affect some aspects of my daily life - Sometimes disruptive **3** = *Severe problem* - They affect all aspects of my daily life - Very disruptive				
IMPACT OF SYMPTOMS ON MY DAILY LIFE	**0 (None)**	**1 (Mild)**	**2 (Moderate)**	**3 (Severe)**
Fatigue Lack of energy, persistent fatigue that does not improve with rest.	☐	☐	☐	☐
Post-exertional malaise Worsening of symptoms or relapses that last for several hours or days after physical, cognitive or emotional effort.	☐	☐	☐	☐
Cognitive difficulties Difficulty concentrating; memory and organization problems; feeling irritated by noise/light, mental fatigue, etc.	☐	☐	☐	☐
Difficulty communicating Difficulty finding your words, following a conversation, understanding people's questions or comments.	☐	☐	☐	☐
Shortness of breath Shortness of breath at rest, during normal activities or when climbing stairs.	☐	☐	☐	☐
Pain/discomfort Headaches, stomach aches, joint or muscle pain, chest pain or tightness, etc.	☐	☐	☐	☐
Palpitations/dizziness Heart palpitations or dizziness when changing position, during activities or at rest.	☐	☐	☐	☐
Stress and negative emotions Feeling anxious, depressed or stressed; having unwanted thoughts or dreams about the illness or hospital stay; having intrusive thoughts, etc.	☐	☐	☐	☐
Sleep problems Difficulty falling asleep, waking up frequently, sleeping for long periods, feeling drowsy during the day, etc.	☐	☐	☐	☐
Cough/irritated throat/voice changes Coughing, choking, throat irritation, altered voice.	☐	☐	☐	☐
Altered smell/taste Change or loss of smell/taste.	☐	☐	☐	☐
Digestive and appetite problems Diarrhea, vomiting, nausea, gastric reflux, loss of appetite, etc.	☐	☐	☐	☐
Do you have any other symptoms? To what degree do they affect your daily life (on a scale of 0 to 3)?				

Nom : Prénom : #Dossier :

CURRENT FUNCTIONING

In the past ***4 weeks,*** to what degree has your condition affected your activities?

0 = *No problem* - Not at all
1 = *Mild problem* - Activities done without too much difficulty (I can manage)
2 = *Moderate problem* - Activities done with significant difficulty (I need help or I have to significantly adjust the way I do things)
3 = *Severe problem* - Activities greatly affected (I have to give up/stop, delegate, or ask for a lot of help)

IMPACT ON ACTIVITIES AND FUNCTIONING	0 (None)	1 (Mild)	2 (Moderate)	3 (Severe)
Movements (walking, bending over, standing, climbing stairs, etc.)	☐	☐	☐	☐
Personal care (washing, dressing, brushing hair, shaving, etc.)	☐	☐	☐	☐
Household tasks (cooking, laundry, errands, driving, etc.)	☐	☐	☐	☐
Family activities (taking care of children/family members)	☐	☐	☐	☐
Main occupation (work, school, volunteer work, etc.)	☐	☐	☐	☐
Leisure activities (sedentary and active)	☐	☐	☐	☐
Social activities (interacting with and helping others)	☐	☐	☐	☐

OVERALL HEALTH

In the past **4 weeks,** how good or bad has your health been?
(10 means the best you can imagine; 0 means the worst you can imagine)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Right now, how **capable** do you feel about facing the challenges related to managing your condition?
(10 means perfectly capable; 0 means completely incapable)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

WINNING CONDITIONS FOR PARTICIPATION

Most CO-VIE interventions take place online (as group workshops on a videoconferencing platform). There are some things that will make it easier for you to participate.

Please check all that apply to you:

☐ I have an Internet connection and a compatible device (computer, tablet, smart phone, etc.).

☐ I have a valid email address that I check frequently.

☐ I can tolerate a workshop lasting about 60-90 minutes (with breaks).

☐ I am available during weekdays.

Comments:

Nom : Prénom : #Dossier :

DOCUMENT TO ATTACH
To complete the service request, the following document must be submitted prior to the start of services (signed by a physician or a specialized nurse practitioner): ☐ Medical referral (or certification of long COVID diagnosis) Send to the following email address: readaptation.covid.cisssmo16@ssss.gouv.qc.ca **Comments:**

REQUEST COMPLETED BY	
☐The patient themselves	
☐A health professional **	Name:
☐Attending physician/SNP **	Title/Relationship with patient:
☐Other **	Telephone:
	Email:
**** If a representative completes this form, they must have obtained prior verbal or written authorization from the patient.**	

Signature of patient (or their representative): _____ **Date:** _____
yyyy-mm-dd

SUBMIT COMPLETED REQUEST
Send this document to the following email address: readaptation.covid.cisssmo16@ssss.gouv.qc.ca Don't forget to also send the medical referral/certificate.

NEED HELP?
Are you in distress or feeling overwhelmed? *Are you having dark thoughts or thoughts of suicide?* *Help is available. Consult the information sheet available online:* https://santemonteregie.qc.ca/sites/default/files/2021/12/f7_mental-health_covid_0.pdf

Note for professionals: Most of the questions in the "Post-COVID symptoms," "Current functioning" and "Overall health" sections are taken from the modified Yorkshire Scale (CR19-YRSm, 2022).