**COVID-19 Swabbing Referral Form**

**When completing referral, please ensure that potential non-covid-19 causes for symptoms have also been considered and investigated.**

**Date: ……………………..**

**Referral Reason: Fever**

 **Persistent Cough (over 24hrs)**

 **SOB or Difficulty breathing**

 **Sore Throat**

 **Loss of taste/smell**

 **Discharge Swab**

 **Admission**

**NHS No: ………………………………**

**Name: ……………………………………………………………………**

**Date of Birth: …………………………………….**

**Dr/Consultant responsible for patient:…………………………………………………..**

**Hospital number (If applicable): ………………………………………………………………..**

**Is the patient nursed on increased observation due to needing to remain in isolation?:Yes/No**

**Observation level:…………………………………………**

**Does the patient have any underlying health condition e.g. Immune**

**compromised?:…………………………………………………………………………………….**

**…………………………………………………………………………………………………………**

**Ward address and Postcode:**

**………………………………………………………………………………………………………….**

**Tel: ………………………………**