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Supporting Information

Supplementary material

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Wrench JM, Seidel Marks LR. An allied health model of care for long COVID rehabilitation. *Med J Aust* 2024; doi: 10.5694/mja2.52457.

ReCOVery Triage Tool

Austin Health have some questions to follow-up your recovery with COVID-19.

Please complete the follow up survey about your recovery with COVID-19 below.

Your responses will help coordinate care services that may help you if you are still living with symptoms of COVID-19.

Thank you.

ReCOVery

Austin Health Post-Acute COVID-19 Service

Date and time _____

A few questions about yourself

[First_Name], to confirm that we have the correct person, could you please provide us with your name, date of birth and contact phone number in the spaces below:

What is your name?

_____

What is your date of birth?

_____
(DD MM YYYY)

What is your phone number?

_____

[First_Name], please answer the following additional demographic questions:

What sex were you assigned at birth?

- ◯ Female
- ◯ Male
- ◯ Another term; please specify
- ◯ Prefer not to answer

Please specify

_____

What gender and pronouns do you identify with?

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents. Pronouns refer to how a person publicly expresses their gender identity.

Please select all that apply.

- ☐ Female/woman
- ☐ Male/man
- ☐ Intersex
- ☐ Non-binary
- ☐ Gender Fluid
- ☐ Transgender
- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ Prefer not to answer
- ☐ Self-described; please specify

Please specify

_____

Are you of Aboriginal and/or Torres Strait Islander origin?

- ◯ No, not Aboriginal or Torres Strait Islander
- ◯ Yes, Aboriginal
- ◯ Yes, Torres Strait Islander
- ◯ Yes, Aboriginal and Torres Strait Islander
- ◯ Don't know
- ◯ Prefer not to answer

Would you like to be referred to Austin Health's Aboriginal Liaison Officer?

- ◯ Yes
- ◯ No

In which country were you born?

- ◯ Australia (includes External Territories)
- ◯ Other; please specify
- ◯ Don't know
- ◯ Prefer not to answer

In which country you were born? Please specify.

_____

Which language do you mainly speak at home? If you speak more than one language, please indicate the one that is spoken most often.	◯ English ◯ Language other than English
What is the main language you speak at home?	◯ Italian ◯ Greek ◯ Cantonese ◯ Mandarin ◯ Arabic ◯ Vietnamese ◯ German ◯ Spanish ◯ Tagalog (Filipino) ◯ Aramaic ◯ Other; please specify ◯ Prefer not to answer
Please specify	_____
Do you require an interpreter?	◯ Yes ◯ No

A few questions about your health and quality of life BEFORE your illness with COVID-19

Please rate your physical health BEFORE your illness with COVID-19

This scale is numbered from 0 to 100.

100 means the best physical health you can imagine.
0 means the worst physical health you can imagine.

0 50 100

(Place a mark on the scale above)

Please rate your mental health BEFORE your illness with COVID-19

This scale is numbered from 0 to 100.

100 means the best mental health you can imagine.
0 means the worst mental health you can imagine.

0 50 100

(Place a mark on the scale above)

Please rate your quality of life BEFORE your illness with COVID-19

This scale is numbered from 0 to 100.

100 means the best quality of life you can imagine.
0 means the worst quality of life you can imagine.

0 50 100

(Place a mark on the scale above)

A few questions about vaccination

Have you been vaccinated against COVID-19?	◯ Yes ◯ No ◯ Unsure
Did you receive your FIRST dose of a COVID-19 vaccine before or after your illness with COVID-19?	◯ Before ◯ After
How many doses of a COVID-19 vaccine have you received?	◯ 1 ◯ 2 ◯ 3 ◯ 4

A few questions about the professional support you have received AFTER your illness with COVID-19

In which year were you first diagnosed with COVID-19?	◯ 2020 ◯ 2021 ◯ 2022
In which month were you first diagnosed with COVID-19?	◯ January ◯ February ◯ March ◯ April ◯ May ◯ June ◯ July ◯ August ◯ September ◯ October ◯ November ◯ December
Have you presented to a Hospital Emergency Department about any symptoms you have/are experiencing since your illness with COVID-19?	◯ Yes ◯ No
How severe was your infection with COVID-19?	◯ I had no symptoms ◯ I had symptoms but remained at home ◯ I was hospitalised ◯ I was hospitalised and received high flow oxygen or was admitted to the intensive care unit ◯ Not sure
Have you seen any medical or healthcare professionals about any symptoms you have/are experiencing since your illness with COVID-19?	◯ Yes ◯ No
What other healthcare professionals have you seen related to your illness with COVID-19? Please select all that apply.	☐ General Practitioner (GP) ☐ Respiratory Physician ☐ Cardiologist ☐ Neurologist ☐ Exercise Physiologist ☐ Physiotherapist ☐ Clinical Psychologist ☐ Clinical Neuropsychologist ☐ Sleep Physician ☐ Dietitian ☐ Speech Pathologist ☐ Other; Please Specify
Please specify	_____

A few questions about your study or employment status

Which of these best describes your study or employment status BEFORE your illness with COVID-19?
Please select all that apply.

- ☐ Working full-time
- ☐ Working part-time
- ☐ Not working due to COVID-19
- ☐ Sick leave
- ☐ Unemployed
- ☐ Engaged in home or carer duties
- ☐ Student
- ☐ Retired
- ☐ Other
- ☐ Prefer not to answer

At the time of your illness with COVID-19, were you studying or working in healthcare?

- ◯ Yes
- ◯ No

What is your main study or employment status today?

- ◯ SAME as before my COVID-19 illness
- ◯ DIFFERENT than before my COVID-19 illness
- ◯ Prefer not to say

Why did your study or employment status change following your illness with COVID-19?

- ◯ Poor health
- ◯ New caring responsibility
- ◯ Working hours reduced by employer
- ◯ Sick leave
- ◯ Made redundant
- ◯ Other
- ◯ Prefer not to say

Which of these best describes your study or employment status AFTER your illness with COVID-19?

Please select all that apply.

- ☐ Working full-time
- ☐ Working part-time
- ☐ Not working due to COVID-19
- ☐ Sick leave
- ☐ Unemployed
- ☐ Engaged in home or carer duties
- ☐ Student
- ☐ Retired
- ☐ Other
- ☐ Prefer not to answer

A few questions about your CURRENT health and quality of life

Please rate how your physical health is TODAY

This scale is numbered from 0 to 100.

100 means the best physical health you can imagine.
0 means the worst physical health you can imagine.

0 50 100

(Place a mark on the scale above)

Please rate how your mental health is TODAY

This scale is numbered from 0 to 100.

100 means the best mental health you can imagine.
0 means the worst mental health you can imagine.

0 50 100

(Place a mark on the scale above)

Please rate how your quality of life is TODAY

This scale is numbered from 0 to 100.

100 means the best quality of life you can imagine.
0 means the worst quality of life you can imagine.

0 50 100

(Place a mark on the scale above)

Below is a list of symptoms that some people may experience. Please indicate which of the following symptoms you have experienced following your illness with COVID-19 and how bothered you have been by them over the PAST WEEK (i.e., 7-days):

	No	Yes; a little bit	Yes; a moderate amount	Yes; quite a lot
Headache?	○	○	○	○
Persistent dry or irritable cough?	○	○	○	○
Loss of sense of smell?	○	○	○	○
Loss of sense of taste?	○	○	○	○
Chest pain?	○	○	○	○
Palpations (heart racing)?	○	○	○	○
Persistent muscle pain?	○	○	○	○
Loss of appetite?	○	○	○	○
Stomach pain?	○	○	○	○
Nausea (feeling sick) or vomiting?	○	○	○	○
Constipation?	○	○	○	○
Diarrhoea?	○	○	○	○
Difficulty falling asleep?	○	○	○	○
Difficulty staying asleep?	○	○	○	○
Shortness of breath or difficulty breathing?	○	○	○	○
Pain on breathing?	○	○	○	○
Problems or changes in your voice? (e.g., hoarseness)	○	○	○	○
Problems with swallowing food, liquids or medications?	○	○	○	○
Problems with reflux, heartburn or stomach acid coming back up?	○	○	○	○
Difficulties with controlling or stopping yourself from worrying about different things?	○	○	○	○
Feeling down, depressed or hopeless?	○	○	○	○
Repeated, disturbing and unwanted memories or dreams related to your illness with COVID-19?	○	○	○	○
Avoiding memories, thoughts or feelings and/or external reminders (e.g., people, activities, objects or situations) related to your illness with COVID-19?	○	○	○	○

Other; please specify	◯	◯	◯	◯

Please describe any other symptoms you have experienced over the PAST WEEK (i.e., 7-days) which began AFTER your illness with COVID-19:

_____

To what degree do you think your difficulties with mood and/or worry are related to your illness with COVID-19?

◯ Not related to my illness with COVID-19
◯ Related to my illness with COVID-19 to a limited degree
◯ Partially related to my illness with COVID-19
◯ Mostly related to my illness with COVID-19
◯ Totally related to my illness with COVID-19

How would you best describe your breathing IN THE LAST 24 HOURS?

◯ Breathless only with strenuous exercise
◯ Short of breath when hurrying on level ground or up a slight hill.
◯ Slower than most people of the same age on a level surface or have to stop when walking at my own pace on level ground.
◯ Stop for breath walking 100 meters or after walking few minutes at my own pace on level ground
◯ Too breathless to leave the house.

Have you lost weight without trying in the last THREE MONTHS?

◯ No
◯ Yes; 1-5kgs
◯ Yes; 6-10kgs
◯ Yes; 11-15kgs
◯ Yes; more than 15kgs
◯ Yes; unsure how much

A few questions about fatigue

Do you currently experience fatigue?

(Tiredness)

- ◯ Yes
- ◯ No

Please rate the intensity of your fatigue on average over the last 24 hours, on a scale from 0 - 10.

0 means no fatigue or tiredness.
10 means severe fatigue or tiredness.

- ◯ 0 (no fatigue or tiredness)
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10 (severe fatigue or tiredness)

A few questions about your thinking and communication skills

Since your illness with COVID-19, have you experienced NEW or worsened with concentrating and/or other aspects of your thinking skills (e.g., memory, problem solving, etc)?

- ◯ Yes
- ◯ No

Please rate the intensity of your difficulties with concentration or thinking skills on average over the past week (i.e., 7-days), on a scale from 0 - 10.

0 means no difficulties with concentration or thinking skills.
10 means severe difficulties with concentration or thinking skills.

- ◯ 0 (no difficulties with concentration or thinking skills)
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10 (severe difficulties with concentration or thinking skills)

Since your illness with COVID-19, have you experienced difficulty with brain fog and/or mental fatigue?

- ◯ Yes
- ◯ No

Please rate the intensity of your brain fog and/or mental fatigue on average over the past week (i.e., 7-days), on a scale from 0 - 10.

0 means no brain fog or mental fatigue.
10 means severe brain fog or mental fatigue.

- ◯ 0 (no brain fog or mental fatigue)
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10 (severe brain fog or mental fatigue)

Since your illness with COVID-19, have you had NEW or worsened difficulty with communication or word finding?

- ◯ Yes
- ◯ No

Since your illness with COVID-19 have you had NEW or worsened difficulty understanding other people?

- ◯ Yes
- ◯ No

Some final questions

While attending our service, which specific problems would you like to receive support or assistance with?

_____

Do you have any comments you wish to make about the survey?

_____

Thank you [first_name] for taking the time to complete this survey about your COVID-19 recovery. We will be in touch after we have reviewed your responses. In the meantime, if you require further assistance, please discuss this with your GP. If it is an emergency, please call 000. If you require urgent support for your mental health, please contact LifeLine (13 11 14). ReCOVery
Post-Acute COVID-19 Service
Austin Health
Email: post-acutecovidservice@austin.org.au
Phone: 0481 469 875 or 03 9496 2235

REDCap Triage Survey - Scoring

Perceived Health Scores:

Perceived overall health and quality of life CURRENTLY

(i.e., average score of current perceived physical health, mental health and quality of life)

_____ (Mean/Average)

Perceived PHYSICAL HEALTH - change over time

(i.e., difference between pre- and post- ratings of perceived physical health)

_____ (Difference)

Higher scores indicate greater perceived change.

Positive scores (e.g., 50) indicate decline between pre-illness and current ratings

Negative scores (e.g., -50) indicate improvement between pre-illness and current ratings

Perceived MENTAL HEALTH - change over time

(i.e., difference between pre- and post- ratings of perceived mental health)

_____ (Difference)

Higher scores indicate greater perceived change.

Positive scores (e.g., 50) indicate decline between pre-illness and current ratings

Negative scores (e.g., -50) indicate improvement between pre-illness and current ratings

Perceived QUALITY OF LIFE - change over time

(i.e., difference between pre- and post- ratings of perceived quality of life)

Higher scores indicate greater perceived change.

Positive scores (e.g., 50) indicate decline between pre-illness and current ratings

Negative scores (e.g., -50) indicate improvement between pre-illness and current ratings

_____ (Difference)

Has at least one individual symptom/s has been endorsed as severe?

Scores = 0 indicate NO. Scores = 1 indicate YES.
IF YES, please review questionnaire responses in addition to below symptom domain scores to assist with determining service eligibility.

_____

Symptom Domain Scores: Scores < 1.2 indicate mild symptoms. INELIGIBLE for service. Scores between [1.3 - 2.2] indicate moderate symptoms. Review symptom matrix (individual items) to determine eligibility and to see if any individual symptom has been endorsed as "severe". Scores between [2.3 - 3.0] indicate severe symptoms. ELIGIBLE for service.

Medical and/or Physical Symptoms TOTAL SCORE

(i.e., symptoms of headache, chest pain, palpitations and/or muscle pain)

_____ (Mean/Average)

Respiratory Symptoms TOTAL SCORE

(i.e., symptoms of cough, shortness of breath, pain on breathing [past week] and/or dyspnoea [past 24-hours])

_____ (Mean/Average)

Gastrointestinal Symptoms TOTAL SCORE

(i.e., symptoms of stomach pain, nausea, constipation, diarrhoea, and/or reflux)

_____ (Mean/Average)

Appetite subscore

(note: calculated to form basis of 'Nutrition TOTAL SCORE' - not to be interpreted in isolation)

_____

Weight loss subscore

(note: calculated to form basis of 'Nutrition TOTAL SCORE' - not to be interpreted in isolation)

_____

Nutrition TOTAL SCORE

_____

Swallowing Difficulties TOTAL SCORE

_____

Speech/Voice Difficulties TOTAL SCORE

_____

Olfactory and/or Gustatory Symptoms TOTAL SCORE (i.e., loss of sense of smell and/or taste)	_____ (Mean/Average)
Fatigue TOTAL SCORE	_____
Sleep Difficulties TOTAL SCORE (i.e., difficulties with falling and/or staying asleep)	_____ (Mean/Average)
Cognitive Difficulties TOTAL SCORE (i.e., difficulties with brain fog and/or concentration/thinking skills)	_____ (Mean/Average)
Mental Health Symptoms TOTAL SCORE (i.e., symptoms of depression, anxiety, and/or PTSD)	_____ (Mean/Average)