



Johns Hopkins Post-Acute COVID -19 Team (JH PACT)

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Email- PACT @jhmi.edu

Ambulatory JH PACT Enrollment Form

******Patient must have had COVID to enroll******

Please note pending specific patient insurance provider Maryland Uniformed Consultation Form may be required in addition

Patient Name: _____ **DOB:** _____ **Phone:** _____

Johns Hopkins medical record number (if known): _____

Home Address: _____

Check applicable option(s) below:

- COVID-19 related hospital admission
- COVID-19 related ongoing pulmonary symptoms/abnormalities
- COVID-19 related ongoing neuropsychological/physical symptoms

When was the patient diagnosed with COVID-19 (If multiple infections please provide all dates):

If the patient was hospitalized for COVID-19 provide hospital name/location:

Is the patient currently on home Oxygen Y/N:

Please check all applicable symptoms the patient is experiencing:

- Fatigue
- Shortness of Breath
- Cough
- Brain Fog
- Cognitive Impairment
- Headache
- Chest Pain
- Neuropathic Pain
- Dysautonomia/POTS
- Other – Please Explain:

Provider Name: _____

Phone: _____ **Fax:** _____

Provider Signature(stamp or e-sign acceptable): _____ **Date:** _____

If patient was not seen at a Hopkins facility, please send

- Documentation of a positive COVID-19 test or summary of clinical diagnosis of COVID-19 without positive test
- Discharge summary for any COVID related hospital admissions
- Most recent clinic notes related to COVID-19 or long COVID

If applicable to the patient OR already completed please send

- Chest X- ray and or Chest CT results
- Echo Results
- Pulmonary function tests
- Physical Therapy, Speech Therapy and/or Occupational Therapy notes

IF THIS FORM IS NOT FULLY COMPLETED, THE PATIENT WILL NOT BE SCHEDULED.
If you have further questions please contact PACT@jhmi.edu. Due to the volume of referrals please note we are typically scheduling new patients several months out.
Please note we are a referral center and cannot accommodate urgent appointments.

