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*Caring for patients with
post-COVID-19 conditions*



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Introduction

Introduction

Evidence regarding the incidence and spectrum of post–COVID-19 illness and management is evolving and will continue to develop in years to come.

The [National COVID-19 Clinical Evidence Taskforce \(https://covid19evidence.net.au/\)](https://covid19evidence.net.au/) continues to monitor and review latest research in this space.

Defining post–COVID-19 conditions

The World Health Organization recently developed a clinical case definition for ‘post–COVID-19 condition’:

Post COVID-19 condition occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually 3 months from the onset of COVID-19 with symptoms and that last for at least 2 months and cannot be explained by an alternative diagnosis. Common symptoms include fatigue, shortness of breath, cognitive dysfunction but also others and generally have an impact on everyday functioning. Symptoms may be new onset following initial recovery from an acute COVID-19 episode or persist from the initial illness. Symptoms may also fluctuate or relapse over time.¹

Another suggested definition that describes a range of post-acute COVID-19 symptoms is ‘chronic COVID-19’ or ‘post–COVID syndrome’; that is, illness extending beyond 12 weeks from initial symptoms.^{2,3}

The term ‘long COVID’ has been commonly used to describe COVID-19 symptoms following acute illness, irrespective of how long the symptoms take to resolve, and could be used to refer to either of the above two conditions.⁴

This guide contains information for general practitioners (GPs) and their teams, who are providing care for patients who have previously tested positive to COVID-19 or have a history suggestive of undiagnosed COVID-19 and have – or are at risk of – post– COVID-19 conditions at any point after the initial acute infection.

Incidence of post–COVID-19 sequelae

The incidence of post–COVID-19 sequelae in those who have tested positive and who have been managed in an outpatient setting (such as management in the home) is thought to be between 10% and 35%, but for those admitted to hospital, this could be closer to 85%.⁵ The incidence of prolonged illness significantly increases with age, comorbidities and initial severity of the acute illness.

In a UK study of 20,000 people who had tested positive to COVID-19, 13.7% reported having symptoms 12 weeks after acute infection.⁶ In an Australian study of 3000 people, 80% reported full recovery within one month, and 5% reported experiencing symptoms after three months.⁷ Other studies reported significantly higher prevalence of symptoms at both time points.³

Studies indicate that the risk of post–COVID symptoms in people who contract COVID-19 after their second dose of COVID-19 vaccine is approximately halved.⁸

Management of post–COVID-19 conditions

Global experience with the epidemics of severe acute respiratory syndrome coronavirus 1 (SARS-CoV-1) in 2003 and Middle Eastern respiratory syndrome (MERS) in 2012 has added to the evidence used in current recommendations in post–COVID-19 management.⁹

General practice presentations in a post-acute COVID-19 scenario are likely to be based on:

- non-specific post-viral symptoms, particularly fatigue, breathlessness, persistent cough and cognitive dysfunction¹⁰
- specific serious sequelae resulting from the acute infection, or as delayed complications
- recovery following severe illness that required intensive care management
- mental health impacts of the acute illness, stigma, ongoing symptoms and functional impairment.

For patients with ongoing symptomatic COVID-19 or suspected post–COVID-19 conditions, a holistic, person-centred approach should be used, including a comprehensive clinical history and appropriate examination that involves assessing physical, cognitive, psychological and psychiatric symptoms, as well as functional abilities.⁴

This resource

The purpose of this resource is to provide advice and support to GPs and their teams when caring for patients with post–COVID-19 conditions, and to encourage the development of individualised plans for their ongoing management.

This document provides generic guidance and should be used to support any local or other more contemporaneous advice, such as the National COVID-19 Clinical Evidence Taskforce [guidelines \(https://covid19evidence.net.au/#living-guidelines\)](https://covid19evidence.net.au/#living-guidelines) and [clinical flowcharts \(https://covid19evidence.net.a](https://covid19evidence.net.a)

[u/#clinical-flowcharts](#)) for the care of people with post-COVID-19 and local [HealthPathways \(https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways\)](https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways), acknowledging that uncertainties remain in our understanding of the sequelae of COVID-19 and its management.

This guide can be used in conjunction with the patient resource, [Managing \(https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms) post-COVID-19 symptoms (<https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms>).

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Identifying patients at risk of post–COVID-19 conditions

Identifying patients at risk of post–COVID-19 conditions

Studies have identified that patients are at higher risk of post–COVID-19 conditions if they:

- have experienced severe illness during their acute COVID-19 illness, including requiring intensive care
- have pre-existing comorbidities (eg respiratory disease, obesity, diabetes, hypertension, chronic cardiovascular disease, chronic kidney disease, post-organ transplantation, active cancer)
- are of older age
- are female.^{4,5,11}

Patients might have already been under your care during their acute illness while isolating at home or might be discharged from another GP or hospital/health service-led COVID-19 service that managed their acute illness. Some patients may not have required, or sought, GP assistance during their acute illness and only present for management of post–COVID-19 conditions.

If the patient was under your care during the acute illness, continue monitoring the patient, even after their release from isolation, based on their symptoms and their risk factors for post–COVID-19 conditions.

Early review after acute illness is recommended when requested in the discharge summary, when a person is determined to be at higher risk of post–COVID-19 conditions or when the patient is still experiencing non-specific post-viral symptoms. These consultations provide an opportunity to assess for any reoccurring or ongoing symptoms, the need for additional supports, and to update management of pre-existing conditions or screening that might have been impacted by their illness. They also allow for early referral to allied health for symptom management, if required.

Patient assessment should include:

- history of acute COVID-19 (suspected or confirmed)
- nature and severity of previous and current symptoms
- timing and duration of symptoms since the start of acute COVID-19
- history of other health conditions
- exacerbation of pre-existing conditions
- mental health and wellbeing
- available supports.⁴

These consultations should be billed as standard attendance items (telehealth or in person).

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Providing patient education

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Arrange a time with the patient to discuss:

- how this health issue intersects with their other personal health history
- common symptoms they might experience after acute COVID-19
- how long they might experience symptoms (most likely to resolve within 12 weeks)
- how to monitor and manage their symptoms at home. Patients can record their symptoms in their 'My post-COVID-19 symptom diary' available in the patient resource, [Managing post-COVID-19 symptoms \(https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms)
- symptoms that might require medical care (eg certain new or worsening symptoms) and where to seek care if they experience these symptoms
- what to expect in the weeks and months following acute COVID-19, including that symptom resolution will be different for each person and that symptoms might fluctuate or change over time
- supports for lifestyle interventions, such as physical activity, nutrition or counselling, to assist with return to usual activities and management of comorbid physical and mental health conditions
- vaccination post-infection if they have not already been vaccinated, or are due for a booster dose
- risks of reinfection and how they can manage this risk. When having these discussions:
 - recognise the patient's health beliefs
 - it is important to acknowledge that the person's symptoms are real
 - acknowledge the mental health impacts of COVID-19 and the isolation experience, demonstrating empathy
 - tailor the message to fit the patient's needs, including their English and health literacy
 - ensure you use an accredited interpreter if the patient requires an interpreter
 - ask the patient if they have any specific concerns that they wish to discuss
 - gain an understanding of the patient's expectations and needs, and develop a decision-making process and management plan together, if required
 - ensure the patient has access to required supports.

Patients might be fearful of stigmatisation of their COVID-19 infection and ongoing symptoms. You can assure your patient that they are no longer infectious after their period of isolation has been completed. It is important to ensure that your patient understands that having some post-COVID-19 symptoms does not mean that they are still infectious. Empower your patient so that they feel comfortable in reassuring their family, friends and employers about this issue, acknowledging that it is natural for people to find these conversations difficult.

Encourage patients and their families to ask questions about post-COVID-19-symptoms. Ensure your patient understands the possible fluctuations in severity and support requirements so that they are fully informed prior to making decisions about their care.

You can share the patient resource, [Managing post-COVID-19 symptoms \(https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms), which includes a symptom diary the patient can fill out and discuss with you during consultations.

Specific sequelae of COVID-19

Specific sequelae of COVID-19

The majority of patients seen in general practice with post-COVID-19 conditions will have had mild or asymptomatic COVID-19 infections. Post-acute COVID-19 symptoms might still occur after mild infection. When assessing any patient, it is important to have an awareness of the known significant sequelae.

Box 1. Significant COVID-19-specific sequelae^{2,3,9,12-14}

Pulmonary:

- Persisting interstitial lung disease
- Impaired lung function
- Pneumonia/lung cavitation
- Dyspnoea
- Complications of intubation/ventilation, including chronic cough, hoarse voice

Endocrine:

- Deterioration of diabetic control
- Osteoporosis due to prolonged immobilisation
- Diabetic ketoacidosis without known diabetes mellitus

Cardiovascular:

- Myocardial infarction
- Myocarditis
- Pericarditis
- Arrhythmia
- Heart failure
- Venous thromboembolism (VTE)

Mental health:

- Worsening of cognitive decline
- Depression
- Anxiety
- Post-traumatic stress disorder following severe illness
- Insomnia/sleep disturbances

Neurological:

- Stroke
- Cognitive impairment
- Encephalopathy
- Epilepsy
- Myelitis
- Critical care neuropathy/myopathy
- Chronic malaise
- Loss of taste and smell
- Paraesthesia
- Cognitive blunting (brain fog)

Post-intensive care syndrome:

- Dyspnoea
 - Anxiety
 - Depression
 - Prolonged pain
 - Reduced physical function
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Haematological:

- Hypercoagulable state
- Anaemia
- VTE

Musculoskeletal:

- Diffuse myalgia
- Joint pain

Rheumatological:

- Post-viral syndrome similar to chronic fatigue syndrome

Paediatric:

- Paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2

Dermatological:

- Hair loss
- Skin rash

General:

- Cardiac/respiratory/musculoskeletal deconditioning
- Reduced nutritional status and weight loss
- Low-grade fevers
- Renal impairment/acute kidney injury
- Gastrointestinal disturbances
- Liver dysfunction
- Pressure sores
- Reduced quality of life

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The most common scenario: Non-specific multisystem post-viral symptoms

The most common scenario: Non-specific multisystem post-viral symptoms

While the specific sequelae of COVID-19 are vast, the majority of patients seeking support from general practice will more than likely experience a range of symptoms, as outlined in Box 2.

Box 2. Post-acute COVID-19 symptoms^{2,3,12,15}

Common symptoms include:

- fatigue
- dyspnoea
- joint pain
- chest pain
- cough
- change in sense of smell or taste
- cognitive disturbances
- hoarse voice

Less common symptoms include:

- insomnia
- low-grade fevers
- headaches
- neurocognitive difficulties
- myalgia and weakness
- gastrointestinal symptoms
- rash
- depression

Management of these presentations will usually be pragmatic and symptomatic. Support your patient to maximise their personal wellbeing through diet, exercise and sleep.

Consider and exclude serious complications and possible alternative causes of ongoing symptoms, such as anaemia. Investigate new or worsening symptoms that could indicate delayed sequelae, such as venous thromboembolism (VTE), cardiac complications or pneumonia.

Where possible, optimise the management of the patient's other chronic conditions.

Identify other social factors that could intersect with their personal health and wellbeing, including smoking, alcohol intake, drug use, risk of mental health issues, risk of family and intimate partner violence, and risk of social isolation.

Consider current recommendations for management of specific symptoms (refer to Box 3). Management should be guided by the patient's specific clinical circumstances and be evidence based. Specialist referral should be undertaken, as required.

Box 3. Management of common symptoms

Breathlessness:[2,3](#)

- Optimise management of pre-existing respiratory conditions
- Recommend respiratory muscle conditioning (pulmonary rehabilitation)
- Consider chest X-ray at 12 weeks for patients who have had significant respiratory illness
- Corticosteroids could be considered for inflammatory lung disease on the advice of a respiratory physician
- Recommend gradual commencement or return to symptom-limited exercise guided by tertiary-trained exercise professionals
- Referral to a speech pathologist for management of chronic cough, hoarse voice or dysphagia
- Consider home pulse oximetry measurement
- Referral to an Accredited Practising Dietitian if symptoms interfere with nutrition, and speech pathology if dysphagia is present

Fatigue:[2,9,16](#)

- Maximise self-care, sleep, relaxation and nutrition
- Recommend that patients pace and be selective when prioritising daily activities
- Recommend caution with return to exercise (reduce if there is any increase in symptoms)
- A monitored return to exercise can be supported by an exercise physiology, physiotherapy or rehabilitation referral
- If fatigue is causing difficulty with activities of daily living (ADLs), recommend energy conservation techniques and home visits by an occupational therapist or rehabilitation service

Chest pain:[2,9,17](#)

- Exclude acute coronary syndrome, myocarditis, pericarditis, pulmonary effusion or pulmonary embolism, and arrhythmia
- Provide education regarding symptoms of concern
- Patients who have had myocarditis or pericarditis as a component of their acute illness should abstain from vigorous exercise for 3–6 months, and athletes should have cardiology supervision for return to training
- Refer for graded increase in low-to-moderate activity to increase mobility, exercise capacity and quality of life; this should be facilitated by a physiotherapist or exercise physiologist, or cardiac rehabilitation program

Headaches, low-grade fevers and myalgia:[2](#)

- Exclude COVID-19 reinfection or recrudescence
- Prescribe simple supportive measures and analgesia or antipyretics, as needed
- Check for secondary infections and prescribe antibiotics, as appropriate

Neurocognitive difficulty:[2,9](#)

- Provide supportive management
- If severe enough to cause difficulty with ADLs, consider cognitive testing, occupational

therapy support and speech pathology support for cognitive communication impairment

Depression/anxiety:[2,18](#)

- Provide information about post–COVID-19 recovery
- Use existing standardised screening tools
- Address multifactorial contributors that might require assistance with pain management, independence with ADLs, financial and other social supports, and loneliness
- Facilitate access to mental health services or online support if patient is unwilling to access face-to-face counselling
- Encourage individualised moderate-intensity exercise initiated and supervised by a tertiary-trained exercise professional
- Refer to an Accredited Practising Dietitian for nutrition support and access to food services

Thrombosis risk and contraceptive choice:[19](#)

- COVID-19 causes a hypercoagulable state in some people, which might worsen the VTE risk associated with combined hormonal contraception. The incidence of VTE in biological females of reproductive age with COVID-19 infection is currently not known
- Patients should be advised of this risk to allow informed choice of contraceptive option
- For biological females who have had mild or moderate COVID-19 and stopped oral menopausal hormone therapy, also known as hormone replacement therapy, if recommencing, consider using a transdermal preparation
- For biological females who have had COVID-19 and who are taking oestrogen-containing contraception, manage these medications as per usual care
- For biological females who have stopped or suspended contraception when they have contracted COVID-19, contraception can be restarted when acute symptoms have resolved

Patient collaboration

Collaborate with the patient to develop an individualised management plan to support their recovery. This might also present an opportunity for the development of multidisciplinary models of care guided by the general practice team, using chronic disease management plans, team care plans and case conference items.

It is important to ensure that if you use specific Medicare Benefits Schedule (MBS) items for this (eg Item 721: GP management plan) that you are familiar with and follow the specific item requirements (including descriptors and notes).

Allied health and other specialist collaboration

Your initial assessment will help inform your management plan. Your patient could benefit from allied health input. Consider collaborating with community and hospital-based allied health, rehabilitation medicine and geriatric medicine services to support individual management planning where appropriate. This might include:

- physiotherapists
- exercise physiologists
- occupational therapists
- dietitians
- speech pathologists
- psychologists
- occupational and environmental physicians
- rehabilitation medicine physicians
- geriatric medicine physicians
- rehabilitation medicine services including outpatients, day rehabilitation and inpatient rehabilitation
- geriatric medicine services including outpatients, and geriatric evaluation and management units.

Multidisciplinary clinics for the management of post-COVID-19 conditions have been established in some jurisdictions. It may be appropriate to refer eligible patients with post-COVID-19 sequelae to these clinics. Eligibility criteria and referral processes will be defined by each jurisdiction. Check your local [Health Pathways \(https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways\)](https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways) or contact your PHN for information on clinics in your area. Alternately your local [Health Pathways \(https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways\)](https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways) might have referral pathways for other allied health and specialist clinics.

Barriers in accessing allied health services might exist for culturally and linguistically diverse (CALD) patients with low English proficiency due to lack of interpreter funding. When referring your patients, ensure the service is able to provide the appropriate care.

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Escalating care for patients with red flag symptoms

Escalating care for patients with red flag symptoms

Red flag symptoms and vital signs are suggestive of severe disease. Patients with red flag symptoms should be immediately assessed. They might require urgent care in a hospital emergency department or by ambulance services.

📌 Red flag symptoms include:¹²

- severe, new onset, or worsening breathlessness or hypoxia
- syncope
- unexplained chest pain, palpitations or arrhythmias
- new delirium, or focal neurological signs or symptoms.

Remember that the patient might have a different illness that is not COVID-19 related. Your assessment should include the consideration of other causes of these symptoms.

Remember if a patient speaks a language other than English and requires an interpreter, provide an explanation about this new situation using an interpreter to reduce the patient's anxiety and maximise their ability to comprehend the situation and management plan. Ensure the patient's cultural needs are met and record specific language and cultural needs in any referral letters.

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Patient support services

Patient support services

People with post–COVID-19 conditions are likely to require additional short-term social supports while they recover. These could include assistance with food preparation and delivery, cleaning or assistance with activities of daily living.

Supports can be arranged via local council, [state/territory health department \(https://www.health.gov.au/about-us/contact-us/local-state-and-territory-health-departments\)](https://www.health.gov.au/about-us/contact-us/local-state-and-territory-health-departments), [My Aged Care \(https://www.myagedcare.gov.au/\)](https://www.myagedcare.gov.au/), the [Centrelink social work services \(https://www.servicesaustralia.gov.au/individuals/services/social-work-services/how-contact-social-worker\)](https://www.servicesaustralia.gov.au/individuals/services/social-work-services/how-contact-social-worker), local charities and many community-specific organisations.

People recovering from COVID-19 and those experiencing post–COVID-19 conditions might benefit from connecting with others with lived experience, if groups are available in the area.

Providing care for specific groups recovering from COVID-19

Providing care for specific groups recovering from COVID-19

People who have had severe COVID-19 requiring hospitalisation

Patients who have had severe illness are likely to have a range of specialty and rehabilitation follow-up plans in place. They might have been discharged to a hospital virtual care service, which might impact a GP's ability to provide MBS-funded consultations. If you are uncertain about whether you can bill MBS items, liaise with the service or your local primary health network.

Consider an earlier telehealth appointment to:

- address any concerns noted in the hospital discharge plan
- discuss any patient or carer concerns
- gain a baseline understanding of symptom severity
- assess potential rehabilitation needs in terms of:
 - physical needs, eg mobility, diet, safety at home
 - cognitive or mood disturbance
 - psychosocial needs, including cultural needs and language support needs
- check that appropriate medical and rehabilitation service follow-up has been organised following hospital discharge
- ensure an action plan is in place if symptoms worsen, and that it includes the management of all health issues, not just post-COVID-19 conditions
- check the patient has access to prescribed medicines immediately and in the longer term
- plan for an appropriate face-to-face assessment soon after the patient is released from isolation.

Management will be determined by the specific sequelae experienced during the patient's hospitalisation (refer to Box 1). Management will also be determined by their other health conditions that require continuing care. There might also be symptoms and signs of treatment-related complications, general deconditioning or post-traumatic stress disorder. In frail, elderly patients, sarcopenia is common.

The duration of a patient's hypercoagulable state post-COVID-19 is currently unknown. Current evidence does not support routine thromboprophylaxis in patients with COVID-19 not requiring hospitalisation, or post-hospital discharge. However, a period of anticoagulant therapy might be appropriate in selected individuals following discharge and should be guided by the hospital team; for example, pregnant or postpartum patients, or those who have had VTE during their admission.^{20,21}

Recommendations for patients discharged following severe COVID-19 include the following:^{16,22}

- Patients should be encouraged to do regular daily activities and low-to-moderate physical exercise (but not high-intensity exercise) in the first 6–8 weeks post-discharge.
- Patients should have a formal assessment of physical and emotional functioning at 6–8 weeks post-discharge, including measurement of respiratory function and exercise capacity, and referral to appropriate services where indicated. These might include:
 - comprehensive rehabilitation service if there are multiple treatable concerns
 - exercise physiology to facilitate a graded increase in activity tolerance if fatigue is preventing completion of pre-COVID-19 activities
 - pulmonary rehabilitation if there is pre-existing or ongoing lung function impairment
 - strengthening exercise and nutritional support programs, if there is loss of strength or muscle mass
 - formal psychological assessment.

It is important to reassess the family/social situation, as carer's leave and financial stability can become an increasing concern at this time.

It should also be noted that patients who were not hospitalised might also experience debilitating symptoms. These patients should similarly be referred to treatment pathways, as described above.

Older people

Medical wellbeing

Proactive surveillance might be required to detect loss of appetite, fatigue, deterioration in function or gastrointestinal symptoms. There could be an increased risk of falls, syncope and delirium.

Patients with functional decline and fatigue might be at increased risk of secondary infections; VTE; poor hydration, malnutrition and poor mouth care; and medicine mismanagement.

For older patients, consider:

- proactive surveillance
- early investigation of symptoms, noting that symptoms might be unreliable
- screening for malnutrition and dehydration
- checking oxygen saturation and blood screening for lymphopaenia, rise in inflammatory markers, hyponatraemia, hyperkalaemia and acute kidney injury.

Maintaining independence and support

Consider the following options to increase support for patients in their homes:

- Home delivery of medicines, including the use of blister packs.
- Assistance with food and meals. Patients can contact [My Aged Care \(https://www.myagedcare.gov.au/\)](https://www.myagedcare.gov.au/) on 1800 200 422 to assist with setting up food delivery services, such as Meals on Wheels, which is available for up to six weeks without an aged care assessment.
- [My Aged Care \(https://www.myagedcare.gov.au/\)](https://www.myagedcare.gov.au/) can also provide a My Aged Care ID number to enable prioritised online grocery ordering.

- The [Older Persons COVID-19 Support Line \(https://www.health.gov.au/contacts/older-persons-covid-19-support-line\)](https://www.health.gov.au/contacts/older-persons-covid-19-support-line) (1800 171 866) is available to older persons, families and carers for support and advice.
- Patients already receiving a home care package through [My Aged Care \(https://www.myagedcare.gov.au/\)](https://www.myagedcare.gov.au/) can also access additional volunteer support through the [Community Visitors Scheme \(https://www.health.gov.au/initiatives-and-programs/community-visitors-scheme-cvs\)](https://www.health.gov.au/initiatives-and-programs/community-visitors-scheme-cvs)

Refer to an Accredited Practising Dietitian for assessment of nutrition support needs when general support is insufficient.

People with disability

There are often challenges in recognising and managing health problems in people with cognitive disabilities, and this is no different during the post-COVID-19 phase.

Carers should be advised about possible post-COVID-19 symptoms, as outlined in Box 2. These might be difficult to pick up by carers unfamiliar with the patient. In patients with cognitive disabilities, carers might need to look for secondary signs, such as increased fatigue, food refusal with anorexia and a decline in skill levels with deterioration in function.

The person might need extra support with mobility and ADLs. The disruption in their life with change of environment, change of carer and changes in their daytime activity might trigger deterioration in behaviour that will take some time to settle after the acute infection and treatment phase. Behavioural change can be especially challenging for carers and needs specific inquiry.

If food refusal or anorexia are noted, consider malnutrition screening and referral to an Accredited Practising Dietitian.

GPs and other health professionals caring for people with disability can access advice from the [COVID-19 Health Professionals Disability Advisory Service \(https://www.health.gov.au/contacts/covid-19-health-professionals-disability-advisory-service\)](https://www.health.gov.au/contacts/covid-19-health-professionals-disability-advisory-service) on 1800 131 330.

People from culturally and linguistically diverse communities

Locally and internationally, COVID-19 infection rates were disproportionately higher in CALD communities, in part due to social determinants of health.³

Ensure you are aware of support resources that you can refer them to, which can be shared with their communities. Healthdirect have [COVID-19 resources \(https://www.healthdirect.gov.au/covid-clarity\)](https://www.healthdirect.gov.au/covid-clarity), including on recovering from COVID, in a number of languages. You can share these resources with patients when English is not their first language.

If an interpreter is required for consultations, practices can use the Australian Government's Translating and Interpreting Service (TIS) Doctors Priority Line. GPs are eligible for a free TIS code. All doctors should be registered. Call 1300 131 450 or visit the [TIS website \(https://tisonline.tisnational.gov.au/Reg\)](https://tisonline.tisnational.gov.au/Reg)

[isterAgency](#)). The RACGP has developed a [fact sheet \(https://www.racgp.org.au/clinical-resources/covid-19-resources/telehealth/telehealth-consultations-using-an-interpreter\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/telehealth/telehealth-consultations-using-an-interpreter) to provide guidance on, and support with, providing telehealth consultations with patients who require an interpreter.

If social worker support is required due to ongoing symptoms, encourage your patient to engage with local services or the [Centrelink social work services \(https://www.servicesaustralia.gov.au/individuals/services/social-work-services/how-contact-social-worker\)](https://www.servicesaustralia.gov.au/individuals/services/social-work-services/how-contact-social-worker). If an interpreter is required, they can call the [Centrelink multilingual phone service \(https://www.servicesaustralia.gov.au/individuals/contact-us/phone-us#languages\)](https://www.servicesaustralia.gov.au/individuals/contact-us/phone-us#languages) on 131 202 and ask for a social worker.

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have disproportionate exposure to social factors associated with risk of severe COVID-19 illness, which in turn is a risk factor for post-COVID-19 conditions.^{23,24}

You can support the cultural safety of Aboriginal and Torres Strait Islander patients by ensuring the following:

- Your practice is welcoming and inclusive (refer to [Step 1: Providing effective, \(https://www.racgp.org.au/the-racgp/faculties/atsi/guides/naccho-racgp-good-practice-tables\)](https://www.racgp.org.au/the-racgp/faculties/atsi/guides/naccho-racgp-good-practice-tables) [culturally safe healthcare \(https://www.racgp.org.au/the-racgp/faculties/atsi/guides/naccho-racgp-good-practice-tables\)](https://www.racgp.org.au/the-racgp/faculties/atsi/guides/naccho-racgp-good-practice-tables) on the National Aboriginal Community Controlled Health Organisation–RACGP resource hub for advice). Many Aboriginal and Torres Strait Islander patients will have had bad experiences in health services, and often attend expecting this to be the case. Knowing this, and taking steps to consciously minimise the risk of another poor experience, allows the patient to receive high-quality care and develop trusting therapeutic relationships.
- Your practice provides an opportunity for patients to identify as Aboriginal and/or Torres Strait Islander and have their response recorded in your clinical information systems. Identifying Aboriginal and Torres Strait Islander patients means that appropriate clinical care can be given, such as recommended immunisations or other preventive care; appropriate Medicare programs can be used, such as item numbers for health assessments, and the Pharmaceutical Benefits Scheme Closing the Gap co-payment; and local referral networks can be used, such as care coordination and supplementary services, or local Aboriginal and Torres Strait Islander health practitioners.
- All practice staff are encouraged to do cultural awareness training (offered free of charge to RACGP members and for a nominal fee for other practice staff via [gplearning \(https://www.racgp.org.au/the-racgp/faculties/atsi/education/post-fellowship/cultural-awareness-and-cultural-safety-training\)](https://www.racgp.org.au/the-racgp/faculties/atsi/education/post-fellowship/cultural-awareness-and-cultural-safety-training)).
- An understanding of the particular circumstances of the patient. How many people are at home with them? What are their cultural and family obligations? Have they got money for food and medications? Have they understood the information that has been given them so far? Do they need any help advocating with other services?

Babies and children

There are limited data on the incidence and severity of post-COVID-19 conditions in babies and children. In a review of 14 studies, the prevalence ranged from 4% to 66%, with a number of limitations identified in these studies.²⁵ The review noted that it is difficult to differentiate post-COVID-19 symptoms from the indirect impacts of the pandemic, such as absence of sports, hobbies, socialising and schooling.²⁵

Severe acute COVID-19 disease is rare in babies and children, so children have a lower risk of post-COVID-19 conditions.²⁶

While very rare, paediatric inflammatory multisystem syndrome (PIMS-TS), which is temporally associated with SARS-CoV-2, must be considered. Common symptoms include fever, abdominal pain, gastrointestinal symptoms (significant vomiting and diarrhoea), neurological symptoms and/or rash.

Parents/guardians/carers should be advised to monitor for these symptoms and other possible post-COVID-19 symptoms, as outlined in Box 2, noting that these might be difficult to pick up in younger children who do not speak yet.

Parents can be reassured that the risk of their child developing PIMS-TS is extremely low.²⁶ They should be reminded that, irrespective of the cause of any severe symptoms, any child who is seriously unwell needs to be treated quickly. There are other conditions that are not related to COVID-19 that a child can develop.

If a child presents with post-COVID-19 symptoms at four weeks post-acute infection, consider referring them for specialist paediatric advice.⁴

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Return to exercise and activity

Return to exercise and activity

A common question GPs encounter is 'when should a patient return to exercise and activity following COVID-19 infection?' As with all illness and injury this will depend on the individual and their initial and ongoing symptoms.

It is important to pace return to exercise and activity. Within the constraints of their symptoms (and under supervision where the patient is deemed to have moderate or high-risk factors) patients should start by setting small goals and working their way up.

Box 3 outlines management of common symptoms experienced post-COVID-19 illness. Addressing these will guide appropriate return to exercise and activity. Your patient could benefit from allied health input to support their return to exercise and activity.

Patients should be educated to cease exercise/activity and seek medical assistance if they experience any red flag symptoms.

Return to work

Return to work

GPs play a key role in assisting patients return to work after injury and illness. Return to work where managed appropriately can be beneficial to a person's physical and mental health and recovery.

When collaborating with the patient to develop their individualised management plan (including return to work), consider the demands of their job and any special requirements of their work (for example, the need to wear certain PPE, perform shift work, fly-in-fly-out) and whether modified duties or reduced hours may facilitate an appropriate return to work.

[Principles on the role of the GP in supporting work participation \(https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/principles-on-the-role-of-the-gp?msclkid=78696a09c03911ecbbac4cd9e9113063\)](https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/principles-on-the-role-of-the-gp?msclkid=78696a09c03911ecbbac4cd9e9113063) have been developed by the Australasian Faculty of Occupational and Environmental Medicine and are supported by the RACGP. The Principles provide clarity around roles and expectations of all stakeholders involved in supporting work engagement, recovery at and return to good work.

Vaccination following infection

Vaccination following infection

While prior infection with SARS-CoV-2 and/or presence of post-COVID-19 sequelae does not contraindicate COVID-19 vaccination, the [Australian Technical Advisory Group on Immunisation \(ATAGI\) now advise](https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance) (<https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance>) that “all people are recommended to defer COVID-19 vaccination for 3 months after a confirmed SARS-CoV-2 infection”²⁷. Vaccination at this time should be encouraged, where the person is eligible.

During recovery, patients might require temporary exemption from COVID-19 vaccination. You can record a patient’s temporary vaccination exemption on the Australian Immunisation Register using the [immunisation medical exemption form](https://www.servicesaustralia.gov.au/organisations/health-professionals/forms/im011) (<https://www.servicesaustralia.gov.au/organisations/health-professionals/forms/im011>) (IM011) (<https://www.servicesaustralia.gov.au/organisations/health-professionals/forms/im011>). Refer to the [ATAGI expanded guidance on temporary medical exemptions](https://www.health.gov.au/resources/publications/atagi-expanded-guidance-on-temporary-medical-exemptions-for-covid-19-vaccines) (<https://www.health.gov.au/resources/publications/atagi-expanded-guidance-on-temporary-medical-exemptions-for-covid-19-vaccines>) for COVID-19 vaccines (<https://www.health.gov.au/resources/publications/atagi-expanded-guidance-on-temporary-medical-exemptions-for-covid-19-vaccines>) and relevant state/territory public health directions for further information on which patients might be suitable for a temporary exemption, what is and is not a valid exemption, and how to appropriately record an exemption. If uncertain, seek advice from your medical defence organisation.

Post-COVID-19 research study participation

Post-COVID-19 research study participation

Research studies are being conducted locally and internationally to gain data and insights into the spectrum of post-COVID-19 conditions and symptom management. Patients may consider participating in local studies.

You can search for COVID-19 studies on the [Australian New Zealand Clinical \(https://www.anzctr.org.au/Default.aspx\) Trials Registry \(https://www.anzctr.org.au/Default.aspx\)](https://www.anzctr.org.au/Default.aspx).

Additional resources

RACGP resources

- [Patient resource: Managing post–COVID-19 symptoms \(https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/patient-resources/patient-resource-managing-post-covid-19-symptoms)
- [Home-care guidelines for patients with COVID-19 \(https://www.racgp.org.au/clinical-resources/covid-19-resources/other-health-issues/covid-19-home-care-guidelines\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/other-health-issues/covid-19-home-care-guidelines)
- [Guide to providing telephone and video consultations in general practice \(https://www.racgp.org.au/clinical-resources/covid-19-resources/telehealth/guide-to-provide-phone-and-video-consultation\)](https://www.racgp.org.au/clinical-resources/covid-19-resources/telehealth/guide-to-provide-phone-and-video-consultation)

Department of Health resources

- [CDNA national guidelines for public health units \(https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm\)](https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm)
- [ATAGI clinical guidance for COVID-19 vaccine providers \(https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance\)](https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance)

National COVID-19 Clinical Evidence Taskforce resources

- [Living guidelines \(https://covid19evidence.net.au/#living-guidelines\)](https://covid19evidence.net.au/#living-guidelines)
- [Clinical flowcharts \(https://covid19evidence.net.au/#clinical-flowcharts\)](https://covid19evidence.net.au/#clinical-flowcharts)

In-language patient resources

- COVID-19 resources in other languages are available from the [Department of Health \(https://www.health.gov.au/resources/translated?f%5B0%5D=field_related_conditions_disease%3A9669\)](https://www.health.gov.au/resources/translated?f%5B0%5D=field_related_conditions_disease%3A9669) and [Health Translations \(https://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf\)](https://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf)
- [National Coronavirus Helpline \(https://www.health.gov.au/contacts/national-coronavirus-helpline\)](https://www.health.gov.au/contacts/national-coronavirus-helpline) – Call 1800 020 080 and select option for interpreter services
- [Centrelink multilingual phone service \(https://www.servicesaustralia.gov.au/individuals/contact-us/phone-us#languages\)](https://www.servicesaustralia.gov.au/individuals/contact-us/phone-us#languages) – Call 131 202

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The RACGP acknowledges the work of the National COVID-19 Clinical Evidence Taskforce (of which the RACGP is a member) in developing [living guidelines \(https://covid19evidence.net.au/#living-guidelines\)](https://covid19evidence.net.au/#living-guidelines) and [clinical flowcharts \(https://covid19evidence.net.au/#clinical-flowcharts\)](https://covid19evidence.net.au/#clinical-flowcharts) for the assessment and management of COVID-19 and post-COVID-19 conditions.

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