Supplementary file 1

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Recommendation	Score 0-10 Mean (95% CI)	Any Comments?
1. Clinicians should follow preventive measures, wear appropriate personal protective equipment according to the local policy and measures should be taken to avoid, or reduce, the risk of droplets production during interventions and activities. Level of evidence: Level 5.	9.23 (8.66-9.91)	*"PPE depended on the phase of rehab?"* *"Assuming policy sensible and in line etc."*
2. Rehabilitation treatment plans should be individual according patient's needs, taking into consideration their comorbidities. Level of evidence: Level 5.	9.70 (9.46-9.97)	
3. For patients with COVID-19, rehabilitation should be aimed at relieving symptoms of dyspnoea, psychological distress and improving their participation in rehabilitation, physical function and quality of life. Level of evidence: Level 5.	9.48 (9.11-9.85)	*"Rehabilitation aims should be dependent upon specific patient symptoms and needs, but this is covered in statement 2. So still agree with this statement."*
4. Patients should be monitored through the entire rehabilitation process. Level of evidence: Level 5.	8.90 (8.23-9.58)	*"Not sure what you mean by monitored. Have follow ups with doctors, wear monitoring devices e.g. Sa02 – not clear."* *"I think we need to allow for some local discretion to be applied. Initial SpO2 monitoring for may not be deliverable."* *"Agree, novel condition so patients will need to be monitored, specifics as to how often they are monitored will depend on patient's full history and comorbidities."*
5. Patient should receive education for their	9.23 (8.73-	*"Agree in principle. Extent of how much advice is given on possible long-term*

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condition and how to cope in the long term. Level of evidence: Level 5.	9.85)	*consequences may be limited due to this being a novel condition. This will need to be addressed in time with more research around long term consequences of COVID-19."*
6. Respiratory complications should be considered in post COVID-19 patients as they may present with some degree of disability and functional limitation, including but not exclusively, due to decreased respiratory function. Level of evidence: Level 2b.	9.38 (8.92-9.85)	
7. Short follow up times are recommended to adjust individual treatment plans as recovery time is likely to differ depending on the degree of dysfunction, normocapnic respiratory failure and patient's physical and mental status. Level of evidence: Level 2b.	9.00 (8.48-9.52)	"*Define short follow up time? Days/weeks/months??"* *"I think this should remain at the discretion of the individual practitioner based on the initial assessment and titrated response to activity within these recommendations."* *"Needs defining in IMO"*
8. Low intensity exercise (<3 Metabolic Equivalent to Task) should be considered initially particularly for patients who required oxygen therapy, whilst concurrently monitoring vital signs (heart rate, pulse oximetry and blood pressure). Gradual increase in exercise should be based on their symptoms of dyspnoea. Level of evidence: Level 5	8.90 (8.23-9.57)	*"Would it also be used to include RPE/ HR range so guidelines are more clinically applicable. I know when I prescribe low intensity exercise e.g. post EBV infection I use these rather than METs."* *"Using METS enables us to trace to the supporting evidence."* *"HR ranges will be patient specific based on premorbid status so will be difficult to justify at a population level but I agree at a practitioner level these could be more useful. Increases in HR should be 8-10bpm per MET to 20 beats above resting would be what I would say to a patient it's just an extra step in the chain to be able to link that to direct evidence."* *"Agree with this in principle. But, not all facilities that are providing rehab input*

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		(e.g. an NHS outpatient SEM facility) may have the capacity to assess all vital signs during exercise for all patients returning to exercise following COVID-19. But agree with statement as it is worded as 'should be considered' and states 'particularly for patients who required oxygen therapy'." *"How do you know they are non covid and does that matter"* *"Exercise prescription should be titrated against symptoms and response to exercise challenge"*
9. Cardiac sequelae should be considered in all post COVID-19 patients, regardless of severity, and all patients should have an assessment of their cardiac symptoms, recovery, functional and potential impairments. Depending on the patient initial assessment and symptoms, specialist advice should be sought and further investigations should include ECG, 24hr-7-day ECG, Echocardiogram, CPET and/or Cardiac MRI. Level of evidence: Level 5	8.52 (7.77-9.28)	*"Are we are going to do the investigation? should clear off prior to rehab?"* *"From what is written it seems this should apply only to those with moderate/severe illness."* *"Very mild symptoms may not require any cardiac investigations or considerations, but agree that it needs to be considered and therefore all patients should be asked about cardiac symptoms to determine whether further assessment is required."* *"My hope is that this is all done prior to entering the rehab space. Our ability to do many of these in the rehab area is poor."* *"Which initial assessment – in acute setting or rehab assessment?"* *"Waffly – either define what the tests are or don't include"*
10. A period of rest post infection depending on symptoms and complications will reduce risk of post infection cardiac failure secondary to myocarditis. Level of	9.19 (8.70-9.68)	We don't know what the symptoms or markers of complications are in COVID?

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evidence: Level 5		
11. If cardiac pathology is present, specific cardiac rehabilitation programmes should be provided tailored to the individual based on their cardiac complications, impairments and rehabilitation needs assessment. Level of evidence: Level 5	9.43 (9.03-9.82)	*"Needs more concise wording"*
12. Patients returning to high level sport following myocarditis require a 3 – 6-month period of complete rest. The period of rest is dependent upon the clinical severity and duration of illness, left ventricular function at onset and extent of inflammation on CMR. Level of evidence: Level 2b	9.19 (8.64-9.74)	
13. Training and high-level sport may resume following myocarditis, if left ventricular systolic function is normal, serum biomarkers of myocardial injury are normal and if relevant arrhythmias are ruled out on 24-hour ECG monitoring and exercise testing. Level of evidence: Level 2a	9.00 (8.44-9.56)	
14. If returning to high-level sport following myocarditis, patients are required to undergo periodic reassessment in particular during the first 2 years. Level of evidence: Level 2a	9.05 (8.65-9.44)	
15. Patients with COVID-19 who required oxygen therapy or exhibited	8.95 (8.49-9.42)	

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lymphopenia acutely should be identified and tested for radiological pulmonary changes and PFT abnormalities. Level of evidence: Level 4.		
16. COVID-19 patients who experience the following symptoms: severe sore throat, body aches, shortness of breath, general fatigue, chest cough, or fever should avoid exercise (> 3METS) for 2-3 weeks after the cessation of those symptoms. Level of evidence: Level 5.	9.19 (8.77-9.61	*"Hull reference now included. I think we need to be mindful of the hyperimmune mediated trend for deterioration around day 8. The Hull reference does not directly cite anything to support 7-10 days. At this stage there is an argument to be more cautious."* *"If an athlete had 1-2 days of any of these symptoms, then according to this recommendation, they should have 2 weeks minimum rest before graded return to training. Some may consider this a bit excessive. I appreciate clinical judgement will need to be applied, and I personally would still err on the side of caution due to this being a novel disease and having severe consequences in some individuals."* *"Sore throat? This assumes new infection? Previously you didn't want to put specific timelines against but now didactic?"*
17. With very mild symptoms likely to be non-COVID-19 related consider continuing some light to moderate activity (<3METs) and limiting sedentary periods. Increase rest periods if symptoms deteriorate. Prolonged exhaustive or high intensity training should be avoided. Level of evidence: Level 5.	8.62 (7.86-9.37)	*"Read as light up to moderate so therefore < 3METS"* Not comfortable with including this
18. Asymptomatic contacts of positive COVID-19 cases should continue to exercise as they would do normally within current government restrictions. Level of evidence: Level	9.19 (8.74-9.64)	

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5.		
~~19. Post COVID-19 patients should have their temperature checked prior to training in a team setting/exercise within two metres of others (once current social distancing measures are lifted). Level of evidence: Level 5.~~	6.19 (4.67-7.71)	*"In the three weeks post episode situation I am not sure of the benefit of this in the absence of symptoms."* *"Pointless and no team sport in near future"* **RECOMMENDATION REMOVED FOLLOWING CHAIRED DISCUSSION ON THE 27th of APRIL 2020.**
20. *(no. 19 in final version)* On return from mild/moderate COVID-19 illness to exercise, one week of trial of low-level bodyweight exercise, stretching and light muscle strengthening activity should be trialled prior to targeted cardiovascular sessions. Patients in the severe category should be identified as per recommendation 15 above with exercise progression following a pulmonary rehabilitation (PR) approach (defined further in pulmonary section of main text) Level of evidence: Level 5.	8.52 (7.85-9.19)	*"Far too wordy"* *"Need to define with METS/RPE to be consistent"*
~~21. Consider increasing self-isolation for obese COVID-19 patients and avoid group exercise during that period. Level of evidence: Level 2b.~~	9.48 (6.16-8.79)	*"Agree given evidence behind this statement. However, may be considered controversial by some."* *"1 size fits all for clear message unless evidence overwhelming"* **RECOMMENDATION REMOVED FOLLOWING CHAIRED DISCUSSION ON THE 27th of APRIL 2020.**
22. *(no. 20 in final version)* In the acute phase, effective communication, social contact (albeit remotely) and an information sheet for people admitted to acute NHS care regarding	8.86 (8.33-9.38)	*"Reword – leaflet on normalisation of psychological sequelae post covid"* *"6 is for the wording of the recommendation, it is essential that these effects are normalised in patients"*

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the psychological sequelae of COVID-19 can help. Level of evidence: Level 5.		
23. *(no. 21 in final version)* Psychological screening should be performed in the recovery phase to identify those who may have adverse psychological outcomes as a result of their COVID-19 experiences. This should focus on trauma, mood and anxiety using standardised questionnaires like GAD-7 and PHQ-9. Level of evidence: Level 2a.	9.14 (8.64-9.65)	*"Not sure if there are more specific questionnaires"* *"Don't like word screening"* *"Identification of ongoing adverse psychological outcomes (trauma mood anxiety) requires further intervention and referral – ish"* *"Need to be careful we don't make problems with normal processing"* *"Using standardised questionnaires. remove the GAD 7 and PHQ9"* *"Again 6 is for wording not for concept"*
24. *(no. 22 in final version)* Active monitoring should be undertaken for those with subthreshold psychological symptoms. Level of evidence: Level 1a.	8.81 (8.11-9.51)	
25. *(no. 23 in final version)* Trauma focused CBT or EMDR, should be offered for those with moderate-severe symptoms of acute stress disorder. Level of evidence: Level 1a.	8.76 (8.17-9.35)	
~~26. Healthcare workers should be screened for mental health problems, including anxiety, depression and post traumatic sequelae. Level of evidence: Level 2a.~~	7.48 (5.93-9.02)	*"One more for the acute space rather than rehab."* *"Should they be screened or should awareness be increased of MH post trauma and staff encouraged to highlight own issues within a safe framework"* **RECOMMENDATION REMOVED BUT AMALGAMATED INTO RECOMMENDATION 23 ABOVE (21 IN FINAL PAPER) FOLLOWING CHAIRED DISCUSSION ON THE 27th of APRIL 2020.**

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27. *(no. 24 in final version)* All patients requiring rehabilitation following COVID-19 should have a functional assessment to determine residual musculoskeletal impairments in order to determine appropriate rehabilitation. Level of evidence: Level 5.	9.43 (9.03-9.82)	
28. *(no. 25 in final version)* Patients that have had an ICU admission should have a multidisciplinary team approach for rehabilitation. Level of evidence: Level 5.	9.48 (9.11-9.85)	
29. *(no. 26 in final version)* Patients presenting with PICS should include rehabilitation efforts focusing on all three domains of impairments: psychological, physical and cognitive. Level of evidence: Level 5.	9.76 (9.52-10.00)	
30. *(no. 27 in final version)* Physical rehabilitation following COVID-19 can be delivered in a series of settings including in-patient, outpatient, in-home telehealth or patient-directed exercises determined according to patient needs. Level of evidence: Level 5.	9.76 (9.52-10)	
31. *(no. 28 in final version)* All COVID-19 patients should be screened for any neurological symptoms, as symptoms can be immediate (at time of active infection) or delayed (in the weeks following COVID-19). This includes a cognitive screen. Level of evidence: Level 2b.	8.48 (7.68-9.27)	*"I would change it to "all COVID-19 patients should be screened for specific neurological symptoms.." particularly common symptoms like headache or dizziness, or symptoms like anosmia which patients may not think to mention."* *"I don't agree that all patients with COVID-19 require a cognitive screen - rather specify those who report cognitive difficulties or have had severe illness*

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		and/or been in ITU."
32. *(no. 29 in final version)* Reassurance should be given that milder neurological symptoms like headache, dizziness, loss of smell or taste and sensory changes are likely to improve with minimal intervention. Level of evidence: Level 4.	8.71 (8.02-9.41)	
33. *(no. 30 in final version)* Education should be provided that moderate neurological symptoms are likely to have a full recovery, but severe symptoms potentially may result in significant or life-changing disability. Level of evidence: Level 3b.	8.86 (8.37-9.34)	*"Yes to the first"* *"I wouldn't necessarily educate on the second part"* *"Impairment"*
34. *(no. 31 in final version)* Consider inpatient multidisciplinary rehabilitation for patients with moderate to severe neurological symptoms to maximise recovery. Level of evidence: Level 5	9.43 (9.06-9.80)	
35. *(no. 32 in final version)* Detailed physical, cognitive and functional assessments should be performed to support return to work in collaboration with Occupational Health. Level of evidence: Level 5	8.71 (7.98-9.45)	*"Not sure detailed work is needed. Should be symptom led and based on patient reporting post education on potential sequalae."*
36. *(no. 33 in final version)* Post COVID-19 medical sequelae should be considered in all patients. Post-acute assessment should include a full medical history and examination, as well as a panel of blood markers. DEXA assessment should	8.57 (7.59-9.55)	*"The text only specifies DEXA in cases of prolonged immobility"* *"Should be done prior to DMRC and formal rehab as part of their pre discharge workup from Hospital"* *"happy with first sentence but too much emphasis on DEXA -out of context."*

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be considered if indicated. Level of evidence: Level 3b		
37. *(no. 34 in final version)* In the presence of multiple pathologies or specialist issues a rehabilitation consultant assessment is recommended with an MDT approach to rehabilitation to manage the wide range of potential sequalae including a dietician (with supplements and micro-nutrient blood panel if required). Level of evidence: Level 1	9.57 (9.20-9.94)	
38. *(no. 35 in final version)* If ongoing medical problems are identified, patients should be referred on to the appropriate medical specialty for further management. Level of evidence: Level 5.	9.76 (9.52-10.00)	
39. *(no. 36 in final version)* In patients with new onset shortness of breath or chest pain, life threatening medical complications should be considered. Level of evidence: Level 5	9.62 (9.25-9.99)	*"Perhaps specify "such as PE""* *"This reads as generally in all patients rather that these are post infected pts (or something along those lines). Basically, you are trying to keep consideration of PE or MI open, rather than the physician assuming it is post COVID dyspnoea and not looking out of the box."* *"I suggest: "In recovering or post-COVID-19 infection patients, with new onset…""*

Supplementary file 1 table1: Recommendation scoring sheet circulated to authors which includes comments and overall score.

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