

**LYMPHOEDEMA SERVICE REFERRAL FORM**

PRIVATE AND CONFIDENTIAL

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| **REFERRAL CRITERIA – LYMPHOEDEMA SERVICE**  **All referrals will require full completion of the standardised referral form**  **INCOMPLETE REFERRALS WILL BE RETURNED** |

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| **Patient Details** | | | |
| **Patient name:**  **Known as:**  **Address:**  **Post Code:** |  | **Tel No:** |  |
| **Date of Birth:** |  |
| **NHS No:** |  |
| **Location of Patient:** |  |
| **CONSULTANT:** |  | **Hospital No:** |  |
| **GP:** |  | **Is the GP aware of referral?** | **Yes / No** |
| **GP Address:** |  | **GP Telephone Number:** |  |
| **PAST MEDICAL HISTORY & OTHER RELEVANT INFORMATION including cancer history. Please attach relevant letters and details of treatment.** | | | |
| **Current medication: (Please list)** | | | |
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| **Please tick site of oedema:**   * **Arm** * **Leg** * **Head/Neck**   **If none of the above please state site:**  **Duration of swelling:**  **Details of any previous treatment for the swelling and how effective this was. Please include whether Diuretics have been prescribed and if the patient has previously been known to a specialist Lymphoedema service:** |

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| **PLEASE READ AND COMPLETE THE FOLLOWING INFORMATION**  **Has the patient:**   * A BMI of 40 or above? Please note that treatment is ineffective in this group of patients (British Lymphology Society's Guidelines, October 2015) . Please refer any such patients to a weight management programme as they will not be accepted by our service until they have lost 10% of their body weight. However, this does not relate to patients with cancer as this will be addressed by the service when treatment is complete.   PLEASE COMPLETE  Current Weight:  Height:  Current BMI:   * Developed swelling secondary to recent surgery? YES/NO   If yes, was this within the last 8 weeks? If so please call the Lymphoedema team to discuss further prior to referral.   * Had a DVT in the last 6 weeks? YES/NO   If yes, is the patient stable and what anticoagulation therapy are they prescribed?  **Had any previous episodes of cellulitis?**  **If yes, date of episode/s:**  **Treatment given:**  **Any history of fungal infections? If yes, please provide details of site and treatment:**    **Evidence of arterial compromise? YES/NO**  **If yes, has the patient been referred to a vascular specialist? Please attach any documentation from the specialist.**  **Please record any recent Doppler results.**  **Have a history of cardiac/renal failure? YES/NO**  **If yes, have they been referred to a specialist? Please attach any relevant documentation.**   * **Had any recent blood screening i.e. FBC, U and E's and LFT's? If not, please ensure these are completed prior to referral and attach.**   **A chronic wound on the affected limb? YES/NO**  **If yes, please note that we are not a wound healing service and so patients with chronic wounds will need to continue under their current wound management service.**  **Will the patient be able to apply compression stockings independently? YES/NO**  **If not, do they have carers that can assist with this?**  **Are there known risk management concerns that would compromise the safety and wellbeing of the patient and members of staff?**  **Is there a previous history of non concordance with prescribed treatment? YES/NO**  **Mobility Status - Please state if wheelchair user YES/NO**  **Does the patient have any communication difficulties?** | |
| **DETAILS OF REFERRING GP, CONSULTANT OR CLINICAL NURSE SPECIALIST (Incomplete referrals will be returned)** | |
| **Name of Referrer (Print): Designation:** | **Date of Referral** |
| **Signature or Email Address of referrer: Contact number:** |

**Completed referrals should be posted, faxed or e-mailed to:**

**Lymphoedema Clinic, St Catherine’s Hospice, Malthouse Road, Crawley, West Sussex, RH10 6BH**

**Telephone: 01293 447333 Fax: 01293 447390 E-mail:** [**stcatherineshospice.admin@nhs.net**](mailto:stcatherineshospice.admin@nhs.net)

**Website:** [**www.stch.org.uk**](http://www.stch.org.uk)