ST CATHERINE'S HOSPICE

**LYMPHOEDEMA SERVICE REFERRAL FORM**

PRIVATE AND CONFIDENTIAL

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

| Patient Details | | | |
|---|---|---|---|
| **Patient name:**<br>**Known as:**<br>**Address:**<br>**Post Code:** | | **Tel No:**<br>**Date of Birth:**<br>**NHS No:**<br>**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** | | | |
| **Has the patient given consent for this referral?** | | | **Yes / No** |
| **Has the patient given consent for their information to be shared between healthcare professionals?** | | | **Yes / No** |
| **Current medication: Please list** | | | |
| | | | |
| | | | |
| | | | |

**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:**

## 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 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? YES / NO**

  **If Yes please give details**

- **Is there a previous history of non concordance with prescribed treatment? YES / NO**

- **Mobility Status. Please state if the patient is a wheelchair user**

- **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**
**Website: www.stch.org.uk**