

**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** | | | |
| **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** | | | |
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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 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   Has a chronic wound on the affected limb? YES / NO  Is the patient currently receiving treatment from a wound healing service eg Healogics? YES / NO  Please provide the name and location of the service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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**](mailto:stcatherineshospice.admin@nhs.net)

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