Thames hospice

LYMPHOEDEMA SERVICE REFERRAL FORM

Please complete both pages - incomplete forms will be returned to referrer

CONSENT AND COMMUNICATION (please ensure this is complete before referring):	
Is the person you are referring aware the referral is being made?	**YES / NO**
Is the person's GP aware this referral is being made?	**YES / NO**

PATIENT DETAILS (please complete all of this section)**:**		
Surname:	First name(s):	
Address:		
Postcode:	Tel No - Home:	Mobile:
Date of Birth: Gender:	Marital status:	Ethnicity:
NHS Number:		
Mobility: No Problems ☐	House Bound ☐	Chair Bound ☐

MEDICAL DETAILS:	**CURRENT MEDICATION/TREATMENT:**
GP Surgery: Address: Tel No: Fax No: **DIAGNOSIS:** **CONSULTANT NAME:** **HOSPITAL:**	**ALLERGIES/SENSITIVITIES:** **Has the patient had the swelling for > 3 months?** **YES/NO** **What part of the body is affected:** **Has the patient had surgery?** **YES/NO** **If yes, what surgery:**

MEDICAL HISTORY:	
BMI >35 ☐ (Refer to Specialist Obesity Service)	**HEMIPLEGIA** ☐ (Not suitable for referral if <6 weeks)
DVT ☐	**ARTHRITIS** ☐

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(Not suitable for referral if <6 weeks) **HYPERTENSION ☐** **SVC OBSTRUCTION ☐** (Only patients with cancer related symptoms to be referred) **CELLULITIS/INFLAMMATION ☐** (Treatment must be completed before referral) **VENOUS/PERIPHERAL VASCULAR DISEASE ☐** (Please forward all relevant diagnostic tests) **WET/LEAKING LEGS ☐** (No suitable for referral)	**HEART FAILURE☐** (Only controlled heart failure are suitable for referral) **RENAL FAILURE ☐** (Only controlled renal failure are suitable for referral) **CHRONIC SKIN DISORDER ☐** **Name of disorder:** **DIABETES ☐** (Only controlled diabetics are suitable for referral)
Is the swelling cancer related? **Chemotherapy:** **Radiotherapy:** **Have any lymph nodes been removed?**	**YES/NO** **Date of treatment:** **Date of treatment:** **YES/NO**
REFERRER DETAILS:	
Name: Address Tel No: Profession: Signature:	Date of Referral: E-mail: Print: