

**LYMPHOEDEMA SERVICE REFERRAL FORM – CANCER RELATED Private & Confidential**

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| **If uncertain if a referral is appropriate please ring (01253) 359219 to discuss further** |

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| 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:** | | | |
| **SITE OF OEDEMA:** | | | **DURATION OF OEDEMA:** | | |
| ABNORMAL SKIN IMPAIRED FUNCTION  PAIN LIMB WEEPING | | | **DATE DIAGNOSED** | | |
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| HOW WAS THE DIAGNOSIS CONFIRMED? Example: Biopsy, X-Ray, Scan | | | | | |
| RELEVANT SURGERY – including dates, histology, extent of lymph node removal | | | | | |
| HAS THE PATIENT UNDERGONE RADIOTHERAPY? – give details and date | | | | | |
| HAS THE PATIENT UNDERGONE CHEMOTHERAPY?- give details and date | | | | | |
| IS THERE ACTIVE DISEASE AT THE TIME OF REFERRAL YES NO | | | | | |
| **SOCIAL CIRCUMSTANCES**  Please consider if the application and removal of compression hosiery is practical and safe Yes No | | | | | |
| **DETAILS OF REFERRING GP, CONSULTANT OR CLINICAL NURSE SPECIALIST** | | | | | |
| Name of Referrer (PRINT) Designation: | | | | | Date of Referral |
| Signature or Email address of Referrer: Contact Number: | | | | |

**Completed referrals should be emailed to:**

**Telephone: 01253 359219 Email:** [**trinity.referrals@nhs.net**](mailto:trinity.referrals@nhs.net)

**Website:** [**www.trinityhospice.co.uk**](http://www.trinityhospice.co.uk) **(includes Health Professionals Guidance)**