

**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**

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