

**Private & Confidential**

**LYMPHOEDEMA SERVICE REFERRAL FORM – CANCER RELATED**

**We will endeavour to see you within 18 weeks**

**N.B. BLS DOCUMENT FOR MANAGEMENT OF CELLULITIS, SECTION 2**

**RELATES TO RECURRENT CELLULITIS**

**All referrals must be TYPED and received in either PDF or WORD format**

*(once complete select ‘File’ & ‘Save as’ to save a copy to attach to an email or click File, Share and ‘send a copy’)*

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| **PATIENTS WITH WOUNDS / ULCER, STOP AND REFER TO DN’S/PRACTICE NURSES****If uncertain if a referral is appropriate please ring (01253) 952571 to discuss further** |

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

**Completed referrals must be typed and emailed to:** **trinity.referrals@nhs.net**

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