

**LYMPHOEDEMA SERVICE REFERRAL FORM – NON-CANCER RELATED**

**Private & Confidential**

**Patients with wounds/ulcer, refer to DNs/Practice Nurses** –

**DO NOT REFER TO LYMPHOEDEMA**

**You will endeavour to be seen within 18 weeks**

**NB: 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.**

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| **If uncertain if a referral is appropriate please ring (01253) 952571 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** |
|  |
| **Mobility Status**Please state if wheelchair bound |
| **BMI**If BMI >30 have you referred to weight management services? **Yes No**  | **Weight:**  |
| **NB: Lymphoedema can be secondary to obesity, therefore referral is contra indicated and weight management will need to be addressed prior to referral.** |
| **SOCIAL CIRCUMSTANCES****Please do not refer if patient cannot safely apply/remove compression hosiery.**Patient can apply Patient has carer who can apply  |
| **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 952571 Email:** **trinity.referrals@nhs.net**

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