

**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**](mailto:trinity.referrals@nhs.net)

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