

**PATIENT REFERRAL FORM FOR LYMPHOEDEMA**

**N.B. ONLY REFER IF HAD LYMPHOEDEMA FOR >3 MONTHS**

**We will endeavour to see all referrals within 16 weeks**

**If you feel there is an URGENT need for our input, please contact the Lymphoedema team to**

**discuss on 01253 952571.**

[**British Lymphology Society**](https://bit.ly/3y9wTBx) **document for management of cellulitis,**

**section 2 relates to recurrent cellulitis**

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| *Referral Criteria** [ ]  **Re-referral for re-measuring for compression**
* [ ]  **Advice for Cancer related issues**
* [ ]  **Appointments for intensive treatments for patents already known to the service**
* [ ]  **New referrals for palliative conditions (life expectancy less than 6 months)**

*Referral Exclusion Criteria** **Unstable Heart Failure – refer to cardiology**
* **Any Leg ulceration or leg wounds**
* **Weeping legs**
* **Arterial insufficiency (Doppler ABPI of <0.8 – refer to vascular)**
* **Patients unwilling or unable to apply compression hosiery**

**NB: BMI –Lymphoedema can be secondary to obesity, therefore weight management will need to be addressed prior to referral. Please provide relevant information below.** |

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

**Please ensure that all relevant information has been given to avoid a delay in processing this referral.**

**Unfortunately, any incomplete forms will be returned to you.**

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| **Patient Details** |
| Patient name: Known as: Address: Post Code: Tel No: Date of Birth:NHS No: Hospital No: |                                                    |

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| **GP and Surgery Details** |
| General Practitioner:       |
| Surgery Address:       |
| Telephone Number:       |

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| **Diagnosis of current problems** |
| **Date diagnosed:**      |
| **Site of Oedema:**      |
| **Duration of Oedema:**      |
| **Does the Patient have a life limiting diagnosis?****No** [ ]  **Yes** [ ]  **(please specify):**       |
| **Mobility Status (Please state if wheelchair bound or using ambulance transport):**      |
| **BMI:**If BMI >30 have you referred to weight management services? **Yes** [ ]  **No** [ ]  | **WEIGHT:**      |
| **Social circumstances:****Please do not refer if a patient cannot, or will not, safely apply/remove compression hosiery.** Patient can apply [ ]  Patient has carer who can apply [ ]   |
| **Summary of Treatment to date and future planned treatment:**      |
| **Any important information regarding disability or communication issues we should be aware of:**      |

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| Patient Name:  |       |  |

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| **Other professionals involved *(name and telephone number)*** |
| Consultant(s):      Specialist Nurse(s):       |
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| **Reason for referral. Please give details of specific problems requiring *Lymphoedema* input**:      |
| **N.B. All assessments are clinic based. The service does not undertake domiciliary assessments.** |
| **PLEASE INCLUDE COPIES OF CURRENT MEDICATION LIST AND RELEVANT CLINIC LETTERS, ONCOLOGY ANNOTATIONS, ETC.** |
| **Referrer’s Details *(Form must be signed by GP, Senior Hospital Doctor, Clinical Nurse Manager or CNS)*** |
| Name of Referrer: *(PRINT)*       | Designation:        | Date of Referral |
| Signature or Email address of Referrer:       | Contact number:       |       |
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**Completed referrals should be emailed to:**

**Telephone: 01253 952571 Email:** **trinity.referrals@nhs.net**

Website: [**www.trinityhospice.co.uk**](http://www.trinityhospice.co.uk)