

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

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