

**LYMPHOEDEMA SERVICE REFERRAL FORM**

**FISHERWICK ROAD, WHITTINGTON, LICHFIELD WS14 9LH**

**Tel: 01543 434563 Email:** [**stg.lymphoedemaclinic@nhs.net**](mailto:stg.lymphoedemaclinic@nhs.net)

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| **St Giles Hospice Admin Only** | |
| Hospice Patient Reference: | |
| CCG: | OAR: |

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| **Patient Details** | | | | | | | |
| Surname: | | | First Name: | | | | Known As: |
| Title: | | | Gender: | | | | Date of Birth: |
| Marital Status: | | | Religion: | | | | Ethnicity: |
| NHS Number: | | | Lives Alone: | | | | First Language: |
| Address: | | | | | | | |
| Telephone: | | | | Mobile: | | | |
| **Next Of Kin/Carer Details** | | | | | | | |
| Name: | |  | | | | | |
| Address: | |  | | | | | |
| Telephone: | |  | | Mobile: | | | |
| Relationship to Patient: | |  | | | | | |
| **GP Details:** | | | | | | | |
| Registered GP: | |  | | | | | |
| Address: | |  | | | | | |
| Telephone: | |  | | | | Email: | |
| **Consultant Details:** | | | | | | | |
| Consultant Name: |  | | | | | | |
| Address: |  | | | | | | |
| Telephone: |  | | | | Email: | | |
| **Referrer Details:** | | | | | | | |
| Referrer Name: | |  | | | Designation: | | |
| Address: | |  | | | | | |
| Telephone: | |  | | | Email: | | |
| Has the Patient consented to the referral: | | | | | Yes / No | | |



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| **Patient Name:** | | | **NHS Number:** | | |
| Reason for Referral: | | | | | |
| Site of Swelling: | Arm / Leg / Trunk / Head & Neck / Genitals | | | | |
| Bilateral / Unilateral | | | | |
| Duration: |  | | | | |
| Pain/Type: |  | | | | |
| History of Cellulitis: | Yes / No | | | | |
| Do you consider the oedema to be: | Mild / Moderate / Severe / Palliative | | | | |
| Skin Condition: | Intact / Broken / Ulcerated / Hyperkeratosis / Lymphorrhoea | | | | |
| Has DVT been ruled out: | Yes / No | | | | |
| District Nurses / Tissue Viability Involvement: Yes / No  **Active leg ulceration needs Tissue Viability input before the Patient can be assessed by the Lymphoedema Service** | | | | | |
| Cardiac & Renal Status:  **Is compression therapy contraindicated? If yes, please enclose relevant correspondence regarding test results and services involved.** | | | | | |
| Mobility: | | | | | |
| Mental Health Status: | | | | | |
| Communication Barriers, ie Hearing loss, visual impairment: | | | | | |
| Risk Alerts, ie C.Diff, MRSA, Tissue Viability, Manual Handling Concerns: | | | | | |
| Allergies, ie Drug Allergies, Skin Sensitivities, Latex Allergies: | | | | | |
| **BMI – Please Read and Action as Appropriate** | | | | | |
| Nutritional Status: | | Height: | | Weight: | \*BMI: |
| Although other factors may contribute to a patient’s oedema, obesity is often the main causative factor of secondary lymphoedema. **Therefore, please note the following:**  **\*BMI over 30:** The patient must be actively engaged in management of their weight and should be referred to a local weight management programme where possible. Please include relevant correspondence where applicable.  **\*BMI over 40:** The patient must be referred to a specialist bariatric/obesity service and must be actively engaged in management of their weight before the referral can proceed. Please include relevant correspondence, where applicable. | | | | | |
| **Important Notes to Referrer – Please Read and Action as Appropriate** | | | | | |
| **GP:** When sending the referral, please attach a Patient Summary, together with results of recent bloods and any relevant correspondence. Please include BMI, Cardiac and Renal Status plus Tissue Viability involvement as outlined above.  **All other Health Care Professionals:** Please include details of the Patient’s GP and any relevant correspondence.  St Giles Hospice Lymphoedema Service will contact the GP for a Patient Summary and other relevant documentation.  **All**: Please attach your annotations and comments, if any, ensuring you quote the patient name and their NHS number on all pages. If the Patient’s Lymphoedema is secondary to cancer or its treatment, please include correspondence regarding diagnosis, lymph node involvement, treatment received and treatment planned. | | | | | |
| **Incomplete Information**: The referral will NOT proceed unless the referral form is completed in full and until the required medical history and correspondence is provided. | | | | | |