Lymphoedema Service Referral Form

Patients Name: Mr, Mrs, Miss, Ms, Other **Address:** **Post Code:** **Tel No.**	**DOB:** **Ethnicity:** **NHS No.**
GP: **Surgery Address:** **Tel:**	**Consultants involved** **Hospital** 1. 2.
Site of Lymphoedema: **Lymphoedema treatment to date:**	
Cancer diagnosis: **Cancer treatment:** **Known metastatic sites**	
Other medical history: **Medication:** **Allergies:** **CPR status (please circle):** FOR CPR / NOT FOR CPR / DECISION NOT MADE	
(please circle) Able to attend clinic / Home Visit required **(must be house bound to qualify for home visit)** **Any requirements specific to patient:** (e.g. hearing/sight/care needs)	
Referrers name: **Signature:** **Date:** **Contact Tel.** **WE MAY NEED TO CONTACT YOU FOR FURTHER INFORMATION PRIOR TO GIVING AN APPOINTMENT**	
Return form to: Lymphoedema Clinic Myton Hospice Myton Lane Warwick CV34 6PX	Tel 01926 838806 Fax 01926 499658
PLEASE ATTACH RELEVANT MEDICAL SUMMARY & MEDICAL LETTERS RE CANCER DIAGNOSIS/TREATMENT	

External referral 03/17 **Office Use only:** Date received:

myton hospice