**Urgent/ Routine**

**Lymphoedema referral form**

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| **Referrer information** |
| **Referring clinician****and job role** |       | **Referral date** | Short date letter merged  |
| **Department and Organisation** | Organisation Name       | **Referrer contact Number** | Organisation Telephone Number  |
| **Address** | Organisation Full Address (stacked)  | **Referrer email address (please ensure a secure email address)** | Organisation E-mail Address  |

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| **Patient Details** |
| **NHS Number:** | NHS Number  | **Name:** | Full Name  |
| **D.O.B:** | Date of Birth  | **Age:** | Age  | **Address:** | **Home Full Address (stacked)**  |
| **Gender** | Gender  |  |  |
| **Ethnicity** | Ethnic Origin  |  |  |
| **Religion:** | Religion  |  |  |
| **Tel:****Mobile:** | Patient Home TelephonePatient Mobile Telephone  | **Other:** |  |
| **NOK Name & contact details:** | Patient Contacts  |  |  |

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| **Key Dataset** |
| **Primary Reason for Referral:** |       |
| **Expected Outcome:** |       |
| **Specialty:**  | **Lymphoedema** |
| **Is the patient vulnerable or do they need help with their booking?****Yes** [ ]  **No** [ ]  **details:**  |

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| **NOTES:*** **Type of appointment required- clinic appointment or home visit- This is must have information so appointment/visit can be planned**
* GP Summary must be attached with the referral
* Site of swelling- left/right/bilateral, arm/leg/head and neck/breast/genital/torso
* Known cause of swelling
* Duration of swelling, previous treatments
* Patients weight, height and BMI
* Risk factors associated with the patient- eg infections, allergies, home environment, history of violence
* If known to another service we ask them to include Doppler readings
* The lymphoedema service is not commissioned to see patients with a BMI>40 who have no other causes for their lymphoedema, unless they are on a successful weight management plan.
* The skin must be dry and intact.

**Referrals are normally seen within 6 weeks of the referral being received. If the patient requires a more urgent assessment please highlight why this may be required and include a contact number so this can be discussed** |

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| **Provisional Diagnosis and Examination Findings (including any red flags), investigations, results:****Problems** **Investigations**  |

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| **History of Problem/Social Circumstances:**i.e.Carer / Emergency contact & Relationship      |

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| **Previous conservative management to date and effect:** |

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| **Medication and Concordance:****Medication**  |

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| **Previous Medical History (including relevant family and investigations history):****Consultations** **Family History**  |

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| **Staff Safety – Are there any issues that we should be aware of which staff should be aware: - YES/NO****If yes, please give details of infection risk, patient or family history:** *i.e.Lone working/Safeguarding issues* |

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| **Special needs of patient – Are there any issues that we should be aware of regarding patient communication** **eg interpreter, disability, carer support?** |

**By submitting this form, I confirm that there is a legitimate/lawful basis to the disclosure of the information contained on the form for the purpose of direct care and consent has been given or is strongly implied.**

 Please send completed forms to: sirona.lymphoedemateam@nhs.net