**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 Telephone  Patient 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](mailto:sirona.lymphoedemateam@nhs.net)