

# Lymphoedema Referral Form

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Please send copies of any clinical correspondence with this form

PATIENT DETAILS	
<b>Patient's Name:</b>	<b>Patient agreement to referral: YES / NO</b>
<b>DOB:</b>	<b>Does the patient live alone? YES / NO</b>
<b>NHS No:</b>	<b>Likes to be known as:</b>
<b>Address – including post code</b>	<b>Main Carer Name:</b>
	<b>Relationship to patient:</b>
	<b>Address – including post code:</b>
<b>Tel No:</b>	
<b>Mobile:</b>	<b>Tel No:</b>
<b>Occupation:</b>	<b>Work No:</b>
<b>Hospital D No:</b>	<b>Mobile No:</b>
MEDICAL DETAILS	
<b>Diagnosis:</b>	<b>Date:</b>
<b>Metastases:</b>	<b>Date:</b>
<b>Recurrence:</b>	<b>Date:</b>
<b>Previous treatment:</b>	
<b>Consultants involved in care:</b>	
<b>GP:</b>	
<b>Surgery:</b>	
<b>Tel No:</b>	
<b>Patient aware of diagnosis: YES / NO</b>	<b>Prognosis: YES / NO</b>
<b>Carer aware of diagnosis: YES / NO</b>	<b>Prognosis: YES / NO</b>
<b>Is there a history of hospital acquired infection? Please specify and include current status: .....</b>	
<b>Is the patient aware of THCF no smoking policy? YES / NO</b>	

<b>Patient's Name:</b>		<b>NHS No:</b>		
<b>HISTORY OF ONSET OF OEDEMA - MAIN PROBLEMS / ISSUES RELATING TO THIS</b>				
<b>PREVIOUS INVESTIGATIONS / TREATMENT</b>				
<b>PREVIOUS MEDICAL HISTORY (Computerised summary if possible)</b>				
<b>CURRENT MEDICATION / ALLERGIES</b>				
<b>SERVICES INVOLVED</b>				
<b>Social Worker / Care Manager:</b>			<b>Tel No:</b>	
<b>Macmillan Nurse:</b>			<b>Tel No:</b>	
<b>Specialist Nurse / Community Matron:</b>			<b>Tel No:</b>	
<b>District Nurse:</b>			<b>Tel No:</b>	
<b>Other: (Please state)</b>			<b>Tel No:</b>	
<b>Is patient:</b> <input type="checkbox"/> At home <input type="checkbox"/> Hospital (If hospital please state Ward) .....				
<b>Referred by:</b>	<b>Designation:</b>	<b>Department:</b>	<b>Tel No:</b>	<b>Date of referral:</b>