LYMPHOEDEMA CLINIC REFERRAL FORM

Referred by: …….. …….

Date: …… Tel. No. ……

Is patient aware of referral? Yes / No

Patient's Details:

Full Name: …….

Address:……

DOB:…….. Tel. No:…….

Post Code: ……..…… Religion:…….. …….

Consultant / Hospital: ……. GP:……

GPs Address:…… Tel. no……..

Diagnosis…….

General Medical History:

Please delete as appropriate if the named patient suffers from or has experienced any of the following:-

Chronic Renal Failure	Yes/ No
Chronic Skin Disorders	Yes/ No
Diabetes	Yes/ No
Heart Failure	Yes/ No
Hemiplegia	Yes/ No
Obesity	Yes/ No
Osteo-arthritis	Yes/ No
Peripheral Vascular Disease/ Arterial Embolism	Yes/ No
Phlebitis	Yes/ No
Rheumatoid Arthritis	Yes/ No
Varicose Veins	Yes/ No
Venous Thrombosis	Yes/ No

Current Medication (please list):……

……

Allergies (please list)……

……..

PTO.

Lymphoedema Secondary to Cancer:

Please complete if appropriate to this patient:

Cancer Diagnosis and Date:…….

Complications of Cancer:	Regional Lymphnode involvement	Yes/ No
	Regional skin involvement	Yes/ No
	Local Recurrence	Yes/ No
	Distant Metastases	Yes/ No

Treatment and Dates:

Surgery:……..Radiotherapy……

Chemotherapy:……..Hormone Therapy……..

Any contra-indications to any aspects of Lymphoedema Treatment? Yes/ No

Any objections to any aspect of Lymphoedema Treatment? Yes/ No

Signature:……..

Designation:…….

Please complete the referral form and return to Elaine Davidson, Lymphoedema Specialist, St. Clare's Hospice, Primrose Tce, Jarrow, Tyne and Wear, NE32 5HA.

Tel: 0191 4516378

Fax: 0191 4516381