

**Lymphoedema Clinica Referral Form**

Post to: Lymphoedema Clinic, Diabetes Centre, 50 Bridport Road, Dorchester, Dorset. DT1 2NQ

Email to: [lymphnurses@dchft.nhs.uk](mailto:lymphnurses@dchft.nhs.uk)

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| --- | --- | --- | --- | --- | --- | --- |
| Please select: | Routine (4-8 weeks) |  | Urgent (1-3 weeks) |  | Palliative (<2 weeks) |  |

## **About the Patient**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | GP’s name |  | | | | |
| Address |  | GP’s address |  | | | | |
| Date of birth |  | Home visit required? | | Yes |  | No |  |
| Hospital/NHS no. |  | Joint visit with community nurse | | Yes |  | No |  |
| Home phone |  |  | |  |  |  |  |
| Mobile phone |  |  |  | | | | |

### Reason for Referral

Area of swelling:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Face/head/neck |  | Arm |  | Breast |  | Abdomen/trunk |  | Genital |  | Leg |  |

|  |  |
| --- | --- |
| Duration of swelling: |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Previous treatment: | Yes |  | No |  | Treatment: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Recent episode of | Yes |  | No |  | Treatment: |  |
| cellulitis: |  |  |  |  |  |  |

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| Is DVT excluded? | Yes |  | No |  |  |  |

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| Is Lymphoedema secondary to cancer? | Yes |  | No |  |

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| If yes, please provide details: |  |
| Surgery: |  |
| Treatment (chemotherapy/radiotherapy): |  |
| Lymph node involvement: |  |

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| **Past Medical History**  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Cardiac problems | Yes |  | No |  | | Vascular/arterial disease | Yes |  | No |  | | Dopplar performed | Yes |  | No |  | | Diabetes | Yes |  | No |  | | Psychiatric history | Yes |  | No |  | | Mobility problems | Yes |  | No |  | | Obesity | Yes |  | No |  | | Details/other Medical Conditions  |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | | | | | |  | | | | | | Dopplar results | |  | | | |  | | | | | |  | | | | | |  | | | | | | Weight: |  | | BMI: |  | |

**Please be aware that if obesity is the cause of lymphoedema, the patient must be willing to embark on a weight loss and exercise programme in order to receive lymphoedema management.**

**Please attach prescription medication chart. Medical history can continue on additional sheet if required.**

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| **Risk Management Concerns (safety or security issues seeing this patient)** |  |

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| --- | --- |
| **BMI/manual handling:** |  |

|  |  |
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| **Allergies (drug/ latex etc):** |  |

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| **Special instructions/cautions/access to property/ keycodes** |  |

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| --- | --- | --- | --- | --- |
| Is the patient aware of referral? | Yes |  | No |  |

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| Is the patient already known to a Lymphoedema service? | Yes |  | No |  |

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| Practice Nurse/District Nurse   |  |  | | --- | --- | | Name: |  | | Team: |  | | Address: |  | | Phone: |  | | Other   |  |  | | --- | --- | | Name: |  | | Team: |  | | Address: |  | | Phone: |  | |
| Additional comments: | |

Following our assessment, a treatment plan will be discussed with the patient. Treatment modalities may include some or all the following:

|  |  |
| --- | --- |
| Skin care | Compression bandaging/hosiery |
| Exercise | Kinesio taping |
| Weight loss | Low level laser therapy |
| Lymphatic drainage | Pneumatic compression pump |

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| --- | --- | --- | --- | --- |
| Do you give consent to these treatments? | Yes |  | No |  |

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| --- |
| If not, please explain reasons why: |
|  |

|  |  |
| --- | --- |
| Referrers name (PRINT): |  |
| Designation: |  |
| Contact address: |  |
| Contact phone number: |  |
| Date: |  |

**Any additional information:**