LYMPHOEDEMA REFERRAL FORM

Worcestershire Health and Care
NHS Trust

Lymphoedema Clinic
Pershore Hospital
Queen Elizabeth Drive
Pershore, WR10 1PS
Tel: 01386 502030 Fax: 01386 502040
whcnhs.lymphoedemaworcestershire@nhs.net

Patient Details

Name ………………………………………………………Tel No. ……………………………

Address: ……………………………………………………………………………………..…...

…………………………………………………………..Post Code: …………………………

Date of Birth: ………………………………………… GP: …………………………………

Practice address/phone no. …………………………………………………………………….

Ethnicity ……………………………………………

GENERAL MEDICAL HISTORY

Please complete the following: Has/does the patient suffer/suffered from any of the conditions below:

Hypertension	YES / NO / CONTROLLED
Heart Failure	YES / NO / CONTROLLED
Hemiplegia	YES / NO / CONTROLLED
Peripheral Vascular Disease/arterial embolism	YES / NO / CONTROLLED
Phlebitis	YES / NO / CONTROLLED
Venous Thrombosis (date and region)	YES / NO / CONTROLLED
Varicose Veins	YES / NO / CONTROLLED
Chronic Renal Failure	YES / NO / CONTROLLED
Chronic Skin Disorders	YES / NO / CONTROLLED
Rheumatoid Arthritis	YES / NO / CONTROLLED
Osteo-arthritis	YES / NO / CONTROLLED
Diabetes	YES / NO / CONTROLLED
Obesity	YES / NO / CONTROLLED
BMI / Weight	YES / NO / CONTROLLED
Liver Disease	YES / NO / CONTROLLED
Thyroid	YES / NO / CONTROLLED
Allergies	YES / NO / CONTROLLED
Other (please verify) ie Smoker	YES / NO / CONTROLLED

If you have answered YES to any of the above, please give details: ……………………………..

…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Please include a copy of the results of blood for U & E's, Thyroid functions and FBCs before referring to the Lymphoedema Service.

Please give your opinion on the cardiac status (is compression therapy contra-indicated?)

……………………………………………………………………………………………………….

Current medication: (attach printout or write)

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Past medical history including past surgery and childhood illnesses): not on general medical list overleaf.

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Lymphoedema History:

Commenced: ………………………………………………………………………………

Past Treatment: ……………………………………………………………………………

Current Treatment: ………………………………………………………………………

Oedema evident in:

Face ☐ Arms ☐ Chest ☐ Abdomen ☐ Genitals ☐ Legs ☐ Other ☐

Do you consider the oedema as:

Mild ☐ Moderate ☐ Severe ☐ Palliative ☐ Day Hospice attended ☐
What day. …………………..

Is the patient complaining of pain: Y ☐ No ☐ Site of pain: ……………..………………

Skin condition: Lymphorroea ☐ Hyperkeratosis ☐ Intact ☐ Ulcerated ☐

Other skin changes, please state: ……………………………………………………………

Mobility: Independent / wheelchair bound / housebound / other

Please include copies of correspondence regarding lymph node involvement, treatment received and treatment planned.

Comments: ……………………………………………………………………………………

Referrer's Details:

Name: ……………………………………………. **Designation:** ………………………………

Address: ……………………………………………………………………………………..

…………………………………………………………………………………………………

Tel. No: ……………………………………………………………………………………

Signed: ……………………………………………..**Date:** ……………………………………..

Referrals will not be accepted without a signature and all sections of the form completed.

It is vital that all sections of the form are completed to make a correct lymphoedema assessment and treatment plan.