Healogics™

Wound Healing & Lymphoedema Centres

Electronic Referral Form

Email: ESXCCG.referralswhc@nhs.net

Tel: 01323 735588

FOR THE ASSESSMENT AND TREATMENT OF LYMPHOEDEMA / CHRONIC OEDEMA AT THE END OF LIFE

PATIENT NAME (inc. title)			NHS NUMBER		
PATIENT ADDRESS			PATIENT TEL NUMBER		
D.O.B			CONSULTANT		
ETHNIC ORIGIN			RELIGION		
RELATIVE/CARER NAME			RELATIVE/CARER TEL NUMBER		
GP NAME & ADDRESS			GP TEL NUMBER		
DISTRICT NURSE			DN TEL NUMBER		
PALLIATIVE CARE NURSE			PAL. CARE NURSE TEL NUMBER		
DIAGNOSIS *(operations & treatment)*			TREATMENT *(please select)*	Hormone	☐
				Chemotherapy	☐
				Radiotherapy	☐
				None	☐
DISEASE STATUS (please *select*)	Regional lymph node involvement	☐	SITE OF OEDEMA		
	Regional skin involvement	☐			
	Local recurrence	☐			
	Distant metastasis	☐			
MEDICAL HISTORY *(please select)*	DVT (within past 6 months)	☐	Venous Disease		☐
	Heart Failure	☐	Vascular Disease		☐
	Hypertension	☐	Hemiplegia		☐
	SVC Obstruction	☐	Arthritis		☐
	Cellulitis/Inflammation	☐	Renal Failure		☐
	Lymphorrhoea	☐	Chronic Skin Disorder		☐
	Diabetes Mellitus	☐	Details		

CURRENT MEDICATION	**Please Print out EMIS data**				
LATEST RESULTS *(please include date)*	Serum Albumin		**KNOWN ALERGIES**		
	Total Protein Levels				
PATIENT APPOINTMENT LOCATION *(please select)*	Clinic	☐	Home Visit		☐
	St Wilfrid's Hospice	☐	St Michael's Hospice		☐
	Hospital (DGH)	☐	Hospital (Conquest)		☐
	Nursing Home	☐	NH Details:		
History of swelling and presenting problems:					

REFERRAL INFORMATION	Name of Person Referring	
	Title	
	Contact Number	
	Date of Referral	

ACCESSIBILITY INFORMATION
Does the patient have any communication difficulties: Yes □ No □ If yes, please state requirements:
Symbols □ Braille □ Sign Language □ Large Print □ Text □ Telephone □ Link worker □
Email □ email address: Other (please state):
Consent for referral including transfer of personal data and medical photography? Yes □ No □
Patients Language : Does the Patient require an Interpreter : Yes □ No □
Does this person have capacity to give consent? Yes □ No □ If not, has the referral been completed in the person's best interest? Yes □ No □
Are there any alerts on this patient that we need to be aware of? Yes □ No □ If yes, please specify:

OFFICE USE ONLY	Referral Accepted			Date referral received:	
	Referral Rejected			Date of assessment:	
	Healogics Number:				
	Comments:				