Lymphoedema

Electronic Referral Form

If you are a practice in Horsham and Mid Sussex CCG please email your request to:
HSCCG.HORSHAM-MIDSUSSEX-CCGREFERRALSWHC@NHS.NET
If you are a practice in Crawley CCG please email your request to:
HSCCG.CRAWLEY-CCG-REFERRALSWHC@NHS.NET

Referral form for the assessment and treatment of Lymphoedema

Patient Name (including title)		**NHS Number**	
		DOB:	
Patient Address:		**Patient Telephone No:** **Mobile No:**	
Ethnicity:		**Religion:**	**Gender:**
First Language:		**Interpreter Required:**	Yes ☐ No ☐
GP Name & Address		**GP Telephone No:**	
		Is GP aware of the referral?	Yes ☐ No ☐

Does the Patient require transport: Yes ☐ No ☐

If a home visit is required is there access arrangement i.e. key codes etc?

REFERRER INFORMATION

Name of Referrer:		Title:	
Contact Number:		Date of Referral:	
URGENCY OF REFERRAL:	Routine ☐	Urgent	☐

Office Use Only

		Referral Accepted	□	Date referral received:	
		Referral Rejected	□	Date of assessment:	
		Healogics Number	□		

Comments:

OTHER HEALTHCARE PROFESSIONALS INVOLVED *(Please provide name and phone number where possible)*

Hospital Consultant	District Nurses	Specialist Nurses	Hospice
Tel No:	Tel No:	Tel No:	Tel No:

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 ☐

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:							
MEDICAL HISTORY *(please tick) Please provide a medical print out where possible*							
DVT (within past 6 months)	☐	SVC obstruction	☐	Lymphorroea	☐	Arthritis	☐
Heart Failure	☐	Cellulitis/inflammation	☐	Venous disease	☐	Renal Failure	☐
Chronic skin disorder	☐	COPD	☐	Liver Disease	☐	Atrial fibrillation	☐
Hypertension	☐	Diabetes mellitus	☐	Hemiplegia	☐	PAD	☐
MEDICATION *(please provide a medication print out where possible)*							
N.B. WHERE A WOUND IS PRESENT *PLEASE PROVIDE PHOTOGRAPHS*							
REASONS FOR REFERRAL							
LYMPHOEDEMA FOLLOWING CANCER DIAGNOSIS Yes ☐ No ☐ *If YES, please tick the following*							
Is current treatment: Adjuvant ☐ Palliative ☐							
Is the patient aware of their diagnosis? Yes ☐ No ☐ N/A ☐							
Is the patient aware of treatment intent? Yes ☐ No ☐							
Regional Lymph node involvement	☐	Distant Metastases	☐	Local recurrence	☐	Regional skin involvement	☐
Treatment (cancer only)	Hormone	☐	Radiotherapy	☐	Chemotherapy	☐	None ☐
Breast Surgery Details : *(Please select all that apply)*							
Mastectomy	☐	Wide local excision	☐	Axillary lymph node dissection (ALND)	☐	Sentinel lymph node biopsy (SNLB)	☐
Wound Infection	☐	Seroma	☐	Cellulitis	☐	Drains	☐
PRIMARY LYMPHOEDEMA: Yes ☐ No ☐	Hereditary	☐	Congenital	☐			
SECONDARY: *(non-cancer related)*							
Lymphoedema secondary to venous disease	☐	Lymphoedema secondary to immobility / dependency	☐	Lymphoedema secondary to obesity	☐	Lipoedema	☐
SITE OF SWELLING:							
Arm(s) **L R**	☐	Head and Neck	☐	Breast **L R**	☐	Genitals ☐	Legs **L R** ☐ Other (state)
DOCTORS ONLY: Can you please provide clarification on the cardiac status i.e. is compression therapy contraindicated? YES ☐ NO ☐ **(if yes, please give details / enclose test results / services involved)**							

History of swelling and presenting problems:			
Duration of symptoms:		**Episodes of Cellulitis:**	
Skin Condition:			
Pain and management:			

ALLERGIES:	Medication:					Dressings products:			
LATEST TESTS *(please provide a print out)*									
Blood results:		Serum Albumin:			Total protein levels:				
ABPI:	Left leg:		Right Leg:			Dates taken:			
BMI:		If >35 is weight loss plan in progress				Yes ☐ No ☐			
ACCESS:	Domiciliary			Clinic			Other *(please state)*		