CANCER RELATED LYMPHOEDEMA SERVICE
OUT-PATIENT CLINIC REFERRAL FORM

THIS SERVICE WILL ONLY ACCEPT FULLY COMPLETED REFERRAL FORMS
(IF NOT FULLY COMPLETED THIS FORM WILL BE SENT BACK WHICH MAY DELAY ASSESSMENT & TREATMENT)

PLEASE POST OR FAX TO:
Lymphoedema Clinic, Saint Catherine's Hospice,
Throxenby Lane, Scarborough, North Yorkshire, YO12 5RE.
Telephone Number: 01723 351421 Fax Number: 01723 356033

Patient Consent Given Yes ☐ No ☐ Patient aware of location of clinic: Yes ☐ No ☐

PATIENT DETAILS:		
NHS Number:		
Date of Birth:		
Surname:		**Weight:**
First Name (s):		**BMI:**
Address:		If BMI > 40 has the patient been referred to a dietician? **Yes ☐ No ☐**
	Postcode:	
Telephone:		Can they attend the clinic? **Yes ☐ No ☐**
Title:		Able to transfer? **Yes ☐ No ☐**
Maritial Status:		Chair bound? **Yes ☐ No ☐**
Male/Female:		
GENERAL PRACTITIONER DETAILS:		Will the patient be able to apply & remove compression hosiery? **Yes ☐ No ☐**
Name of GP:		
Surgery Name & Address:		If not, is social help in place if required? **Yes ☐ No ☐**
	Postcode:	
Telephone:		
Fax:		
Name of Consultants involved *(please include hospital and contact details, also attached any relevant scans and clinic letters)*		
Reason for Referral: *(Please provide details of cancer and treatments to date)*		
Lymphoedema secondary to cancer/ treatment:		

Acknowledgement goes to Lincolnshire Community Health Service NHS Trust for permission granted for the use of content within this referral form

Past Medical History: *(please tick all relevant boxes)*			**Diagnosis:** *(with dates if known)*
DVT (within the last 6 months)	**Yes** ☐	**No** ☐	
Heart Failure	**Yes** ☐	**No** ☐	
Hypertension	**Yes** ☐	**No** ☐	
SVC Obstruction	**Yes** ☐	**No** ☐	
Cellulitis	**Yes** ☐	**No** ☐	
Lymphorrhoea (wet legs)	**Yes** ☐	**No** ☐	
Obesity	**Yes** ☐	**No** ☐	
Diabetes	**Yes** ☐	**No** ☐	
Chronic skin disorder	**Yes** ☐	**No** ☐	
Renal failure	**Yes** ☐	**No** ☐	
Arthritis	**Yes** ☐	**No** ☐	
Hemiplegia	**Yes** ☐	**No** ☐	
Venous disease	**Yes** ☐	**No** ☐	

Is there evidence of venous or arterial insuffcicency? **Yes** ☐ *(give details)* **No** ☐

Please provide ABPI and full assessment

History of swelling / onset / limb(s) affected:

(please tick if applicable)

Other areas affected: ☐ **Digits** ☐ **Head and Neck** ☐ **Trunk** ☐ **Breast** ☐ **Genitals**

Skin: ☐ **Fragile** ☐ **Broken/ulcerated** ☐ **Taut/shiny** ☐ **Thickened**

☐ **Limb weeping** ☐ **Tissue is non-pitting & fibrotic** ☐ **Limb distorted shape**

☐ **Pain** ☐ **Recurrent infection**

Please attach current care plan and wound assessment if active ulcers or wounds present

Investigations: *(Has the patient had recent investigations into their swelling? If so, please attach copies of recent blood tests, scans, cardiac echo etc)*

Does the patient have current infection, eg MRSA, C-diff etc? **Yes** ☐ *(please specify)* **No** ☐

Last Wound swab result: *(if applicable)*

Date:

Other relevant information/current medical history: *(To include if patient is known to any othe healthcare professionals, mobility, communication/understanding issues etc)*

REFERRER DETAILS: ***(please print)***	
Name:	**Date of referral:**
Position:	
Address:	
Telephone:	**Fax:**