

**SWYPFT BARNSLEY LYMPHOEDEMA SERVICE (cancer related only)**

**CLINIC REFERRAL FORM**

**SWYPFT Lymphoedema Service, Apollo Court Medical Centre, 45 High Street, Dodworth, Barnsley, S75 3RF**

**Telephone: 01226 645180 / Email** [**barnsleylymph@swyt.nhs.uk**](mailto:barnsleylymph@swyt.nhs.uk)

***Please note: This service will only accept fully completed referral forms.***

***(If not fully completed, this form will be returned, which may delay assessment and treatment)***

**C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngDoes the patient have a diagnosis of Lymphoedema secondary to cancer diagnosis or cancer treatment?**

Yes No

***Please note: If the patient does not meet the criteria above the service will be unable to accept the referral***

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Mental Capacity: Yes No

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| --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | |
| **NHS Number:** | | **Date of Birth:** | | **Male/Female:** |
| **Title:** | | **Surname:** | | **First Name(s):** |
| **Full Address**  (including postcode) |  | | | |
| **Telephone:** | | | | |
| **Marital Status:** | | **Religion:** | | **Ethnic origin:** |
| **EMERGENCY CONTACT** | | | **Weight:**  **BMI:**  If BMI >40 has the patient been referred to a dietician?  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png **Yes No**  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngCan they attend the Clinic?  **Yes No**  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngAre they able to transfer? **Yes No**  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngAre they chair bound? **Yes No**  Will the patient be able to apply & remove compression hosiery?  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png **Yes No**  If not, is social help in place if required?  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png **Yes No** | |
| **Contact Name:** | | |
| **Relationship:** | | |
| **Address:**  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png | | |
| **Is this person next of kin?**  Yes No | | |

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| **GENERAL PRACTITIONER DETAILS** | |
| **Name of GP & Practice:** |  |

|  |  |
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| **Name of Consultants involved:** (please include hospital and contact details, also attach any relevant scans and clinic letters) |  |

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| C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png**Any other Healthcare Professional involved? Yes No**  (If yes, please provide details): |

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| **Diagnosis:** (with dates if known) | | |
| **Past Medical History:**  (Please provide **print out of summary** or list significant recent history) | **List of current medication:** | |
| **Are co-morbidities stable?** i.e. renal, heart failure, DVT | | |
| **Has the patient been reviewed medically to exclude any other medical cause for the swelling?**  *i.e. Doppler, CT Scan, DVT, Disease recurrence*  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png  Yes No  If yes, please list recent investigations and results | | |
| **Is there evidence of venous or arterial insufficiency?**  Please provide Doppler reading results, (ABPI) and full assessment | | C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png Yes No |
| **History of swelling / date & cause onset / limb(s) affected:**  Please tick if applicable:  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png  **Further affected:** Upper Limb Lower LimbDigits Head & Neck Trunk  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png  Breast Genitals  ------------------------------------------------------------------------------------------------------------------------------------------------------------------  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png  **Skin:** Fragile Broken/Ulcerated Taut/Shiny Thickened Weeping  **C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png**C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png  **C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngTissue is:** Pitting Non pitting Fibrotic  ------------------------------------------------------------------------------------------------------------------------------------------------------------------  C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].png**C:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngC:\Users\racheld\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\9PWZXY42\checkbox-unchecked[1].pngOther:** Limb distorted shape Pain Recent episode of cellulitis Neurological Deficit  Please attach current care plan if applicable: | | |
| **Other relevant information & recent/current infections:**  (To include communication/understanding issues, social history etc) | | |

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| --- | --- | --- | --- | --- | --- |
| **REFERRER DETAILS** | | | | | |
| **Name:**  (please print) |  | **Position:** |  | **Date of Referral:** |  |
| **Address:** |  | | | | |
| **Telephone:** |  | | **Email:** | | |

**Inclusion Criteria**

* The patient resides in a community setting i.e. own home, care home, hospice.
* Patients must be registered with a GP within Barnsley CCG.
* The patient must be 18 years or over.
* The patient has a diagnosis of Lymphoedema that is secondary to cancer diagnosis or cancer treatment
* Any healthcare professional requesting input from the Specialist Lymphoedema Service must ensure that the patient has been reviewed medically to exclude any other medical cause for the swelling.
* Re-referral on condition deterioration following planned discharge.

**Exclusion Criteria**

* At this time any patients referred for lymphoedema treatment that is not secondary to a cancer diagnosis will be declined.
* Patients under the age of 18 years.
* Patients without a confirmed diagnosis or without any evidence of full investigations into swelling having been carried out, as this may compromise patient safety and they will be referred back for information and assurance
* Patients who are not in a stable phase of their co-morbidities, e.g. uncontrolled heart failure
* Non-housebound patients who are unable to travel to the lymphoedema clinic at Barnsley.