Cancer Lymphoedema Service Referral Form *(May 2024)*

*Please note the sections marked with a* \**are mandatory fields and must*

*be fully completed or the referral will be rejected.*

Date of referral: ………………………………………

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| **\*PATIENT DETAILS** Name: Address: DOB: Post Code:NHS Number: Telephone Number:  |
| **\*REFERRED BY** Name: Telephone Number: Consultant [ ]  GP [ ]  Specialist Nurse [ ]  Hospital Ward / Speciality [ ]  Practice Nurse [ ]  Community Pharmacists [ ]  Self-Referral [ ]  Other [ ]  Registered GP and Practice:  |
| **EXCLUSION CRITERIA** *Please note referrals received for patients with the following will be declined:-** At this time any patients referred for lymphoedema treatment that is not secondary to a cancer diagnosis will be declined.
* 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.
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| **\*INCLUSION CRITERIA** *Please ensure ALL the boxes are ticked, failure to confirm these points will result in the referral being rejected:-** The patient resides in a community setting i.e. own home, care home, hospice. [ ]
* Patient must be registered with a Barnsley ICB registered GP Practice. [ ]
* Patient must be 18 years or over. [ ]
* The patient must have a diagnosis of Lymphoedema that is secondary to a cancer diagnosis or cancer treatment. [ ]
* Any healthcare professional requesting input from the Cancer Lymphoedema Service must ensure that the patient has been reviewed medically to exclude any other medical cause for the swelling. [ ]
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| **PATIENT WEIGHT AND MOBILITY STATUS** *Please complete and tick as appropriate:-*Patients BMI: If BMI >40 has the patient been referred to a dietician? Yes [ ]  No [ ]  Is patient: Fully Mobile [ ]  Chair Bound [ ]  Bed Bound [ ]  Will the patient be able to apply & remove compression hosiery? Yes [ ]  No [ ]  If not, is social help in place if required? Yes [ ]  No [ ]  |
| **\*DETAILS OF SWELLING / LIMB(S) AFFECTED**  **Body parts affected:** Upper Limb [ ]  Lower Limb [ ] Digits [ ]  Head & Neck [ ]  Trunk [ ]  Breast [ ]  Genitals [ ] **Skin:** Fragile [ ]  Broken/Ulcerated [ ]  Taut/Shiny [ ]  Thickened [ ]  Weeping [ ]  **Tissue:** Pitting [ ]  Non pitting [ ]  Fibrotic[ ]  **Other:** Limb distorted shape [ ]  Pain [ ]  Recent episode of cellulitis [ ]  Neurological Deficit [ ]  Has the patient been reviewed medically to exclude any other medical cause for the swelling? (i.e. Doppler, CT Scan, DVT, Disease recurrence). Yes [ ]  No [ ]  If yes, please list recent investigations and results:Is there evidence of venous or arterial insufficiency? Yes [ ]  No [ ]  Please provide Doppler reading results, (ABPI) and full assessment. |
| **DIAGNOSIS (Including any chemotherapy / radiotherapy treatments previously received or on-going)** |
| **PAST MEDICAL HISTORY / DISABILITIES INCLUDING ARE CO-MORBIDITIES STABLE?** |
| **MEDICATION:** |