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: ………………………………………

|  |
| --- |
| **\*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. |
| **\*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. |
| **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:** |