**ALL WALES LYMPHOEDEMA SERVICE REFERRAL FORM 2016**

**Please complete all sections as much as possible**

|  |  |  |
| --- | --- | --- |
| Name & Title: | | Hospital/NHS No: |
| Address:  Postcode:  Telephone: Mobile: | | Patient’s GP:  GP Surgery: |
| **Location of patient on referral:**  ⬜ Home ⬜ Other \_\_  ⬜ Hospital & Ward |
| Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_  Gender: ⬜ Male ⬜ Female | |
| **Lymphoedema History:**  Area of Swelling: Duration of Swelling: \_\_\_  Severity of Swelling: ⬜ Mild ⬜ Moderate ⬜ Severe ⬜ Palliative  Lymphorrhoea (Leaking) ⬜ No ⬜ Yes Duration: Referred to Dermatology: ⬜ No ⬜ Yes  Ulcers ⬜ No ⬜ Yes ⬜ Venous ⬜ Arterial Referred to TVN: ⬜ No ⬜ Yes  Cellulitis ⬜ No ⬜ Yes No. episodes in past 12 months: Patient in bandages: ⬜ No ⬜ Yes | |

**Cancer History Related to Lymphoedema** ⬜ **Not Applicable**

|  |
| --- |
| Diagnosis: Date of Diagnosis: \_\_\_\_\_\_\_\_\_  Surgery ⬜ No ⬜ Yes ⬜ N/A Procedure: \_\_\_  Chemotherapy ⬜ No ⬜ Yes ⬜ N/A Nodes Removed: ⬜ No ⬜ Yes Nodes Positive: \_  Radiotherapy ⬜ No ⬜ Yes ⬜ N/A Advanced Disease at Referral: ⬜ No ⬜ Yes |
| **Past Medical History Details / Other Medical Conditions**  Cardiac Problems ⬜ No ⬜ Yes \_\_\_  Vascular/Arterial Disease ⬜ No ⬜ Yes \_\_\_  Diabetes ⬜ No ⬜ Yes \_\_\_  Psychiatric History ⬜ No ⬜ Yes \_\_\_  Obesity ⬜ No ⬜ Yes Weight: \_\_\_  Mobility Problems ⬜ No ⬜ Yes Stand to transfer ⬜ No ⬜ Yes Requires hoist ⬜ Yes |

**Please attach prescription medication chart. Medical History can continue on additional sheets if required**

**Special Instructions / Cautions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns over patient’s mental capacity? ⬜ No ⬜ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient aware of referral: ⬜ No ⬜ Yes Is patient already known to a Lymphoedema Service: ⬜ No ⬜ Yes **PTO for flowchart:** ⬜ Routine (includes Prevention) ⬜ Urgent ⬜ Palliative

|  |
| --- |
| Referrers Name **(PRINT):** Designation: \_\_\_ \_\_ Contact Address: \_\_ \_ Contact Tel no: \_ Date: \_ \_\_\_\_\_ \_ \_ |

**Lymphoedema Clinic**

**Tel: Fax:**

**All Wales Lymphoedema Service Referral Flow Chart**

Referral to the

LYMPHOEDEMA SERVICE

Adequate Information on the Referral Form?

Please contact the lymphoedema clinic for telephone advice in supporting patients whilst they wait for an appointment.

If you have any referral queries regarding ticking urgent or routine please contact the clinic.

**PALLIATIVE**

Patient contacted for urgent appointment within 2 weeks

Palliative is described as people who are at the end stage of life regardless of cause

If a patient fails to attend an agreed appointment without prior notice they will automatically be **discharged**.

**URGENT**

Will be seen within

4 weeks

Yes

**ROUTINE**

**(Includes Prevention)**

Will be seen within

12 weeks

No

* Head and neck oedema?
* Genital oedema?
* Chronic Breast Swelling? (>3 months)
* 2 or more episodes of cellulitis in the past year requiring IV antibiotics?
* Acute Lymphorrhoea (leaking) within last 3 months?
* Paediatric - under 18?

No

Yes

Contact Referrer for more information- this will not delay the appointment process

**DECISION ON PATIENTS NEEDS**

Does the patient have advanced disease?

No

Yes