**Lymphoedema Service Referral Form**

# The Clatterbridge Cancer Centre NHS FT, Wirral, CH63 4JY Tel: (0)151 556 5015

**Please email this form to:** [ccf-tr.lymphoedema@nhs.net](mailto:ccf-tr.lymphoedema@nhs.net)

# \*PLEASE NOTE THAT FOR ALL LOWER LIMB REFERRALS, IF THERE IS A SUDDEN ONSET OF SWELLING A DOPPLER ULTRASOUND MUST BE PERFORMED PRIOR TO REFERRAL. RESULTS MUST BE SENT WITH REFERRAL.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| REFERRER DETAILS: | | | | |
| **Name of Referrer:** |  | **Designation:** | |  |
| **Date Referred:** |  | **Contact Details:** | **Email:** |  |
| **Tel No:** |  |
| PATIENT DETAILS: | | | | |
| **Forename:** |  | **Surname:** | |  |
| **Title:** |  | **Date of Birth:** | |  |
| **Address:** |  | **Contact Tel No:** | |  |
| **Gender:** |  | **Marital Status:** | |  |
| **Ethnic Origin:** |  | **Religion:** | |  |
| **GP Name:** |  | **GP Address:** | |  |
| **GP Code:** |  | **GP Contact No:** | |  |
| **NOK Name:** |  | **NOK Relationship:** | |  |
| **NOK Address:** |  | **NOK Contact Tel No:** | |  |
| PATIENTS SOCIAL DETAILS: | | | | |
| **Details of patients Social**  **Situation ie lives alone etc:** |  | **Occupation/Duties:** | |  |
| **Details of Support in place ie, involvement of DNs etc:** |  | | | |
| PAST MEDICAL HISTORY (Attach clinical print-out if possible): | | | | |
| **Diagnosis (including node involvement, treatment**  **and treatment plan):** |  | | | |
| **Surgery to Lymph nodes:** |  | **History of Cording:** | |  |
| **Wound infection at surgery site:** |  | **Patients awareness of diagnosis/prognosis:** | |  |
| **Significant Past Medical History:** |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications:** |  | | |
| RISK MANAGEMENT CONCERNS: | | | |
| **Alerts (MRSA/Tissue Viability? Manual Handling**  **Concerns):** |  | **If other, please state:** |  |
| **Specific details of any**  **alerts:** |  | **Known Allergies:** |  |
| **BMI >35:** |  | **Any other Comments:** |  |
| INFORMATION REGARDING LYMPHOEDEMA | | | |
| **Area of swelling:** |  | **If other, please state:** |  |
| **Duration of swelling:** |  | **Is swelling static:** |  |
| **Heaviness:** |  | **Pain:** |  |
| **Numbness/Tingling/Altered**  **Sensation:** |  | **History of Oedema:** |  |
| **Recent Doppler performed:** |  | **History of Cellulitis if yes\* please complete details in comments**  **section:** |  |
| **Any other comments:** |  | | |
| Additional Comments: *e.g. dates to avoid, patient on holiday etc.* | | | |
|  | | | |
| CCC Use Only: | | | |
| **Date referral received at**  **CCC:** |  | **Referral Accepted:** |  |
| **First appointment:** |  | **Special instructions:** |  |