**Lymphoedema Referral Form**

**Please note ALL of the form must be completed or it will be returned**

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| **Patient’s Details**  Surname……………………………….. First name(s)…………………………………….  Date of birth…….../…….../……... NHS no:……..………………….…………..……  Address……………………………………..……………………………………………………………  GP name………………………………. GP tel no……………………….…………………  GP surgery……………………………………..……………………………………………………….  Is the patient housebound requiring a Home Visit?........................................………….Yes/No  Has the patient consented to the referral? ………………………………………….……..Yes/No  Clinical history/location of swelling  ………………………………………………………….………………………………………………..  …………………………………………………………………………………………………………… |
| **Referrer’s Details (if different to above)**  Name………………………………… Designation……………………………  Tel no……………………………….. Date of referral…….../………/……… |
| **Reason for referral**  Cancer….Yes/No (See section 1) Non cancer …..Yes/No (See Section 2) |
| **Section 1**  **Cancer details**  Is the disease inactive…………………………………………………………………………Yes/No  …………………………………………………………………………………………………………….  Diagnosis……………………………………….…………………………….. Date……/……/…….  Surgery……………………………………………………….……………….. Date……/..…./…….  Chemotherapy……………………………………………….… Approximate Date……/..…./…….  Radiotherapy……………………………………………..…….. Approximate Date……/..…./…… |
| **Section 2**  **Non-Cancer details**  **Please note we DO NOT complete Doppler assessment. These should be completed before referral to our lymphoedema service**  1. Is there any evidence of arterial compromise? ………………………..……….….……Yes/No  If yes, please refer to a vascular specialist and attach any documentation  ABPI right = ………. left = ……….. Date taken ……/……./…….  2. Current BMI ...…….  If above 40, please refer to a weight management programme as lymphoedema treatment alone is likely to be ineffective in this patient group (British Lymphology Society’s guidelines, October 2015)  3. Does the patient have wounds/ulcers/maceration……………………….…..………....Yes/No  If yes, please refer to District Nurse/Practice Nurses/TissueViability/dermatology as we are not a wet leg or wound service  4. Does the patient have a history of cardiac/renal failure?............................................Yes/No  If yes, please consider referral to a specialist as we would not see patients with uncontrolled disease. Please attach any relevant documentation  5. Is the patient able to apply compression garments independently?...........................Yes/No  If no, please ensure carers are in place to assist with this |
| **Please email with PMH/medication records and any relevant clinical correspondance to**  [stch.clinical.admin@nhs.net](mailto:clinicaladmin@stcatherines.co.uk)  **Please note this is not a secure email address. It is the responsibility of the referrer to ensure appropriate measures are in place.** |
| Children and out of area patients can be seen by St Catherine’s lymphoedema service however funding would need to be agreed by their local clinical commissioning group before we are able to assess the patient. |

**Referral Criteria for the Lymphoedema Service**

**Indications for Referral**

Chronic swelling linked to predisposing factors:

Trauma and tissue damage eg lymph node dissection, radiotherapy, vein surgery

Malignant Disease

Venous Disease eg recurrent ulceration, post DVT

Infection eg recurrent cellulitis, filariasis

Inflammation eg RA, psoriatic arthritis

Dependency-related swelling

Primary eg hereditary, congenital syndrome

**Exclusion Criteria**

Post-op swelling eg up to 6 weeks post-surgery

Uncontrolled cardiac/renal failure

Superior Vena Cava Obstruction (SVCO)

Severe vascular insufficiency

Acute DVT

**Please consider:**

If onset of swelling is sudden, exclude presence of thrombosis or recurrent/advancing disease and initiate appropriate action

Patients who currently have cellulitis, please refer to the BLS guidelines for management of cellulitis at:

www.wwl.nhs.uk/media/community-pdfs/BLS-cellulitis-guidelines.pdf