

**LYMPHOEDEMA SERVICE REFERRAL FORM – CANCER RELATED Private & Confidential**

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| **If uncertain if a referral is appropriate, please ring (01624) 647456 to discuss further** |

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| Patient name:Known as:Address:Post Code: | Tel No: |  |
| Date of Birth: |  |
| NHS No: |  |
| Location of Patient: |  |
|  |
| **CONSULTANT:** |  | **Hospital No:** |  |
| **GP:** |  | **Is the GP aware of referral?** **Yes** [ ] **No** [ ]  |
| **GP Address:** |  | **GP Telephone Number:** |
| **SITE OF OEDEMA:** | **DURATION OF OEDEMA:** |
| ABNORMAL SKIN [ ]  IMPAIRED FUNCTION [ ]  PAIN [ ]  LIMB WEEPING [ ]  |  |
| What is the diagnosis |
| RELEVANT SURGERY – including dates, histology, extent of lymph node removal |
| HAS THE PATIENT UNDERGONE RADIOTHERAPY? – give details and date |
| HAS THE PATIENT UNDERGONE CHEMOTHERAPY/ - give details and date  |
| IS THERE ACTIVE DISEASE AT THE TIME OF REFERRAL YES [ ]  NO [ ]  **Past Medical History:** |
| **SOCIAL CIRCUMSTANCES**Please consider if the application and removal of compression hosiery is practical and safe Yes [ ]  No [ ]   |
| **DETAILS OF REFERRING GP, CONSULTANT OR CLINICAL NURSE SPECIALIST** |
| Name of Referrer (PRINT) Designation: | Date of Referral |
| Signature or Email address of Referrer: Contact Number: |

**Please ensure patients are aware this information will be held on computer according to the General Data Protection Regulations and that our privacy notice is available on the Hospice Isle of Man website.**

**Does the patient agree to Hospice clinical staff accessing their GP and Hospital clinical record?** Yes [ ]  No [ ]  If no, is there any particular reason for this? Please state ……………………………………………………...

**Please email completed referrals to** **referrals@hospice.org.im**

 **or post to the Clinical Administrator, Hospice Isle of Man, Strang, Douglas IM4 2RP**

**Website:** [**www.hospice.org.im**](http://www.hospice.org.im) **(included Health Professional Guidance)**