Mr Mrs Miss Ms Other (please circle) Patients Name: Address: Post Code:	Telephone Number: DOB: NHS No.	
GP : Surgery Address: Tel:	Consultant 	Hospital
Site of Lymphoedema: Lymphoedema treatment to date:		
Cancer diagnosis: : Cancer treatment: Known metastatic sites: Lymph node involvement: **PLEASE ATTACH RELEVANT MEDICAL SUMMARY AND LETTERS REGARDING CANCER TREATMENT**		
Other medical history: Medication: Allergies:		
Able to attend clinic / Home Visit required (please circle) If home visit required state reason: Moving and Handling issues: Moving and handling equipment: Any requirements specific to patient: (e.g. hearing/sight/care needs)		
Referrers name: Signature: Date: Contact details:		
Please return form to: Lymphoedema Clinic Mary Ann Evans Hospice Eliot Way Nuneaton CV10 7QL	Telephone number: 02476 865452 Email: geh.maryannclinical@nhs.net	

Date referral received		Clinic Number	
1st Contact Letter/phone		1st Assessment	