Lymphoedema referral form

<table>
<tr><td colspan="2" rowspan="3">Mr Mrs Miss Ms Other (please circle)
Patients Name:
Address:

Post Code:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="2">DOB:</td></tr>
<tr><td colspan="2">NHS No.</td></tr>
<tr><td colspan="2" rowspan="3">GP :
Surgery Address:

Tel:</td><td>Consultant</td><td>Hospital</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="4">Site of Lymphoedema:

Lymphoedema treatment to date:</td></tr>
<tr><td colspan="4">Cancer diagnosis:
:
Cancer treatment:

Known metastatic sites:

Lymph node involvement:
PLEASE ATTACH RELEVANT MEDICAL SUMMARY AND LETTERS REGARDING CANCER TREATMENT</td></tr>
<tr><td colspan="4">Other medical history:

Medication:

Allergies:</td></tr>
<tr><td colspan="4">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: (eg hearing/sight/care needs)</td></tr>
<tr><td colspan="4">Referrers name: Signature: Date:

Contact details:</td></tr>
</table>

Return form to:	Lymphoedema Clinic Mary Ann Evans Hospice Eliot Way Nuneaton CV10 7QL	Telephone Number : 024 76 865452 Fax Number: 024 76 865438

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