

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

**NB: BLS DOCUMENT FOR MANAGEMENT OF CELLULITIS, SECTION 2 RELATES TO RECURRENT CELLULITIS**

**DO NOT REFER TO LYMPHOEDEMA CLINIC**  
**PATIENTS WITH WOUNDS/ULCER, REFER TO DN'S/PRACTICE NURSES.**

Patient Details			
<b>Patient Name:</b> <b>Known as:</b> <b>Address:</b>  <b>Post Code:</b>			<b>Tel No:</b>
			<b>Date of Birth:</b>
			<b>NHS No:</b>
			<b>Location of patient:</b>
<b>CONSULTANT:</b>			<b>Hospital No:</b>
<b>GP:</b>			<b>Is the GP aware of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>GP Address:</b>			<b>GP Telephone Number:</b>
<b>Site of Oedema:</b>		<b>Duration of Oedema:</b>	
ABNORMAL SKIN <input type="checkbox"/>	IMPAIRED FUNCTION <input type="checkbox"/>	<b>DATE DIAGNOSED:</b>	
PAIN <input type="checkbox"/>	LIMB WEEPING <input type="checkbox"/>		
<b>Mobility status</b> Please state if wheelchair bound. <b>Past Medical History:</b>			
<b>BMI</b> If BMI > 40 Have you referred to weight management services      Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Weight:</b>			
<b>NB: Lymphoedema can be secondary to obesity therefore referral is contra indicated and weight management will need to be addressed prior to referral.</b>			
<b>SOCIAL CIRCUMSTANCES</b> Please do not refer if patient cannot safely apply/remove compression hosiery. <b>Patient can apply <input type="checkbox"/></b> <b>Patient has Carer that can apply <input type="checkbox"/></b>			
DETAILS OF REFERRING GP, CONSULTANT OR CLINICAL NURSE SPECIALIST			
Name of Referrer (Print)		Designation:	<b>Date of referral:</b>
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 fax completed referral form to FAX No. 01624 647460, or post to the Clinical Administrator, Hospice Isle of Man, Strang, Douglas IM4 4RP**

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