LYMPHOEDEMA SERVICE REFERRAL FORM – CANCER RELATED

Private & Confidential

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

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 fax completed referrals to Fax No: 01624 647460
or post to the Clinical Administrator, Hospice Isle of Man, Strang, Douglas IM4 2RP

Website: www.hospice.org.im (included Health Professional Guidance)