Hospice IOM Palliative Lymphoedema and Oedema Management Service

Private & Confidential

Email completed referrals to referrals@hospice.org.im

Referral eligibility

Does the patient have an advanced progressive life-limiting illness within the last 12 months of life? ☐ Yes ☐ No

If **No**, this referral does not meet the eligibility criteria for the Hospice Palliative Lymphoedema and Oedema Management Service. Please refer to the Manx Care Tissue Viability Lymphoedema Service.

If uncertain whether a referral is appropriate, please telephone **(01624) 647456** or email **lymph@hospice.org.im**.

Does the patient require urgent assessment - within 5 working days? ☐ Yes ☐ No

Patient name: **Known as:** **Address:** **Post Code:**		**Preferred contact No:**	
		Date of Birth:	
		NHS No:	
		Current Location: ☐ Home ☐ Hospital ☐ Care Home ☐ Other – Specify:	
Consultant:		**GP Practice:** **(Inc. Telephone No.)**	

Reason for referral – (*Tick all that apply*):

☐ New oedema
☐ Rapid increase in oedema
☐ Increase in pain
☐ Skin Changes
☐ End-of-life symptom management
☐ Education
☐ Other - specify:
☐ Lymphorrhoea (leakage)
☐ Recurrent Cellulitis
☐ Compression review
☐ Functional Decline
☐ Advice regarding compression contra-indications

Site of Oedema	**Left**	**Right**	**Bilateral**
Upper limb	☐	☐	☐
Lower limb	☐	☐	☐
Breast / Chest wall	☐	☐	☐
Head & Neck	☐	☐	☐
Genital	☐	☐	☐
Truncal	☐	☐	☐
Generalised	☐	☐	N/A
Other (specify):			

Current Management – what management has already been attempted (*Tick all that apply)*

☐ Compression garment
☐ Compression bandaging
☐ Elevation
☐ None
☐ Exercise/movement
☐ Skin care
☐ Manual Lymphatic drainage/massage
☐ Other:

Outcome/Reason current management is no longer effective:

Primary Life-Limiting Diagnosis	
Co-morbidities affecting oedema management: ☐ Heart Failure ☐ Neuropathy ☐ Renal disease ☐ Frailty ☐ Vascular disease	
Relevant Previous Cancer Treatment (If Applicable): ☐ Surgery ☐ Radiotherapy ☐ Systemic Treatment Relevant details:	
Active cancer present? ☐ YES ☐ NO ☐ NOT APPLICABLE	
Can the Patient Safely Manage Compression? Independently ☐ Requires assistance ☐ Unable ☐ Not appropriate ☐	
Referrer details	
Name of Referrer (PRINT): Designation:	Date of Referral
Signature or Email address of Referrer: Contact Number:	

Patient Consent

Please ensure the patient is aware that their information will be stored securely and processed in line with data protection requirements, and that the Hospice Isle of Man privacy notice is available on the Hospice Isle of Man website www.hospice.org.im.

Does the patient consent to Hospice clinical staff accessing their GP and hospital clinical records for the purpose of assessing this referral and planning care? Yes ☐ No ☐

If **No**, please state the reason, if known:

Does the patient consent to the referral being discussed within the Hospice multidisciplinary team, if required for care planning? Yes ☐ No ☐

If **No**, please state the reason, if known:

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