CLEARLYMPH

Certified Lymphoedema Therapist and Registered Nurse providing assessment and management of lymphoedema and lipoedema.

REFERRAL FORM

**PATIENTS DETAILS**

NAME:

DOB:

ADDRESS:

TELEPHONE NUMBER:

NHS NUMBER:

HEIGHT:

WEIGHT:

BMI:

**GP DETAILS**

NAME:

ADDRESS:

TELEPHONE NUMBER:

| PLEASE LIST PREVIOUS MEDICAL HISTORY, INCLUDING ANY SURGICAL PROCEDURES |
| --- |
| |

| CURRENT LIST OF MEDICATION |
| --- |
| |

- ***If lymphoedema is secondary to cancer please include copies of correspondence regarding diagnosis, lymph node involvement, treatment received and treatment planned.***

**ANY KNOWN ALLERGIES?**

**CARDIOVASCULAR STATUS**

Please give your opinion on the patient's cardiovascular status:

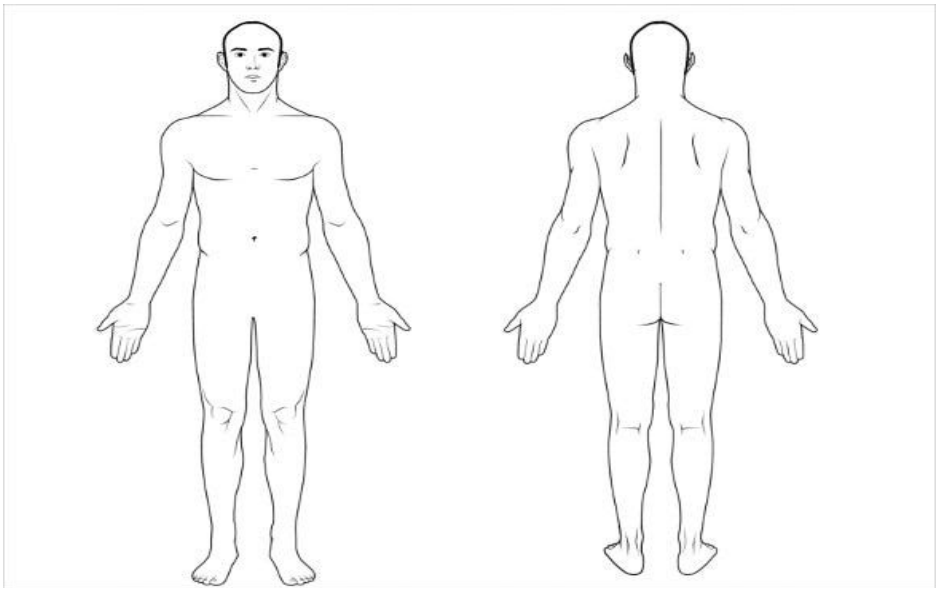
| | | |
| --- | --- | --- |
| CARDIAC PROBLEM | YES | NO |
| VASCULAR PROBLEM | YES | NO |

**ARE THERE ANY CONTRAINDICATIONS TO COMPRESSION THERAPY?**

**HAS A DVT BEEN RULED OUT?**

**LYMPHOEDEMA/LIPOEDEMA/CHRONIC OEDEMA**

**Please indicate on the body map below areas affected by oedema**



**DO YOU CONSIDER THE OEDEMA TO BE (PLEASE CIRCLE)**

MILD MODERATE SEVERE PALLAITAIVE

**SKIN CONDITION (PLEASE CIRCLE)**

LYMPHORRHEA ULCERATED

PLEASE STATE IF ANY OTHER SKIN CHANGES:

**MOBILITY (PLEASE CIRCLE)**

INDEPENDENT WHEELCHAIR BOUND HOUSE BOUND OTHER

**ARE THERE ANY SAFETY CONCERNS/ALERTS WITH THIS PATIENT?**

NO

YES - PLEASE COMMENT:

**REFERRER DETAILS:**

NAME:

DESIGNATION:

TELEPHONE NUMBER:

DATE:

SIGNATURE: