



Lymphoedema Service Referral Form

SERVICE FOR PATIENTS WITH LYMPHOEDEMA SECONDARY TO CANCER ONLY

Tick preferred site: - Christie Bolton Beechwood Cornerstones

Patient's Name: _____ **G.P Name:** _____
Hospital Number: _____ **Address:** _____
Date of Birth: _____ _____
Address: _____ **GP postcode:** _____
 _____ **Tel No.** _____
Postcode _____ **Referred by:** _____
Tel no: Home: _____ **Date referred:** _____
Mobile: _____ **Designation:** _____
Consultant: _____ **Contact No:** _____
Cancer Diagnosis: _____

REASON FOR REFERRAL

Lymphoedema in **Arm** **Head & Neck** **Breast**
 Leg **Genital**

Please state side of swelling **Left,** **Right,** **Bilateral**

Recent episode of cellulitis? **Yes** **No** **Date:** _____

Is lymphoedema secondary to advanced disease? **Yes** **No**

If yes details _____

Has a DVT been excluded? **Yes** **No**

Details of previous cancer treatment: _____

PLEASE COMPLETE BOTH SIDES OF THE FORM. INCOMPLETE FORMS WILL BE RETURNED WITHOUT THE PATIENT BEING ADDED TO THE WAITING LIST.

Special Requirements. O2- Transport- Interpreter- Language Required _____

Other _____

Past Medical History:

Drug History:

Social History:

Service Referral Criteria

- **Lymphoedema secondary to cancer only**
- Other causes of lymphoedema need to be excluded prior to referral to the service eg. DVT, vascular problems, cardiac or renal problems.
- Swelling related to chemotherapy/drug therapy is not covered by the lymphoedema service

Please send your completed form to The Christie irrespective of where you wish the patient to be seen and they will be triaged.

PLEASE SEND ALL REFERRALS TO : -

**LYMPHOEDEMA TEAM
The Christie
Rehabilitation Unit
Wilmslow Road
Manchester
M20 4BX**

Tel: 0161 446 3795 - OR - email lymphoedema.service@nhs.net

Please do not send referrals to personal emails.