St Luke's Lymphoedema

PLEASE NOTE:
We are a therapist led service and need accurate information and a confirmed diagnosis of lymphoedema in order to safely assess and treat your patient. Please complete both sides of form.

PATIENT DETAILS:

Title: Name:	Hospital No: NHS No:
Address: Postcode: Telephone numbers:	Consultant: GP: GP Surgery:
Date of Birth: Gender:	Location of patient (specify): ☐ Home ☐ Hospital Ward _____ ☐ Other _____

LYMPHOEDEMA HISTORY:

Area of Swelling:	Duration of Swelling:
Reason for Swelling:	

Severity of Swelling:	☐ Mild	☐ Moderate	☐ Severe	☐ Palliative
Lymphorrhea	☐ Yes	☐ No	Duration:	
Ulcers	☐ Yes	☐ No	☐ Venous	☐ Arterial
Doppler Date:	☐ Yes	☐ No	☐ Left	☐ Right
Cellulitis	☐ Yes	☐ No	Number episodes past 12 months:	

CANCER HISTORY: (If applicable)

Diagnosis:	Date of Diagnosis:

Active disease at referral?	☐ Yes	☐ No	
Surgery?	☐ Yes	☐ No	Procedure:
Chemotherapy	☐ Yes	☐ No	Date:
Nodes Removed:	☐ Yes	☐ No	Number Positive:
Radiotherapy	☐ Yes	☐ No	Date:

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PAST MEDICAL HISTORY:			Details:	
Smoker?	☐ Yes	☐ No	How many?	How long?
Cardiac problems	☐ Yes	☐ No		
Vascular/Arterial Disease Duplex Assessment	☐ Yes ☐ Yes	☐ No ☐ No		
Diabetes	☐ Yes	☐ No		
Psychiatric history	☐ Yes	☐ No		
Obesity	☐ Yes	☐ No	Weight:	BMI:
Immobility Stand to transfer	☐ Yes ☐ Yes	☐ No ☐ No	Requires Hoist?	
Thyroid disease	☐ Yes	☐ No		
Renal disease	☐ Yes	☐ No		

SPECIAL INSTRUCTIONS / CAUTIONS:		
Is compression therapy safe?	☐ Yes	☐ No
Any concerns over patient's mental capacity?	☐ Yes	☐ No
Is patient aware of referral?	☐ Yes	☐ No
Patient already known to Lymphoedema service?	☐ Yes	☐ No

☐ Urgent	☐ Routine	☐ Palliative

REFERRER DETAILS:	
Referrer Name: (print)	Signature:
Designation:	Contact Tel No:
Location:	Date:

Please return the completed form to:
St Luke's Lymphoedema Service
St Luke's Hospice Plymouth
Stamford Road
Turnchapel
Plymouth
PL9 9XA
Tel: 01752 246600 Fax: 01752 481878