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 Nodes Removed:	Yes Yes	No No	Date: 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 email the completed form to:
livewell.stlukeslymphoedema@nhs.net

or post to:

St Luke's Lymphoedema Service
St Luke's Hospice Plymouth
Stamford Road
Turnchapel
Plymouth
PL9 9XA Tel: 01752 246600 Fax: 01752 481878