LEWIS-MANNING HOSPICE
LYMPHOEDEMA CLINIC REFERRAL FORM

Post to: Lymphoedema Clinic, Lewis-Manning Hospice, 1 Crichel Mount Road, Lilliput, Poole, Dorset, BH14 8LT
Fax to: 01202 672660
This referral form can be downloaded from the website: www.lewis-manning.co.uk

1. ESSENTIAL PATIENT INFORMATION

Patient's Name	Patient's Address with Post Code	Telephone Number
Current location of Patient		**Date of Birth**
		Patient aware of referral Yes ☐ No ☐

2. REFERRED BY

Name and position	Contact number	Signature & Date

3. PATIENT'S GP AND SURGERY

Telephone No:

GP aware of referral Yes ☐ No ☐

4. OTHERS INVOLVED (name and phone number where possible)

- **Hospital Consultant(s)**
- **District Nurses**
- **Specialist Nurses**

5. CARER / SOCIAL HISTORY (especially due to home visit)

6. DIAGNOSIS

Patient Aware Yes ☐ No ☐

Patient aware of end of life stage (when appropriate) Yes ☐ No ☐

Relevant surgery/treatment to date:

History of swelling/onset/limb affected:

Signs of Infection	**Yes ☐**	**No ☐**	**Treatment**
Evidence of Neuropathy	**Yes ☐**	**No ☐**	
Venous of Arterial insufficiency	**Yes ☐**	**No ☐**	**ABPI =**
Has Thrombosis been excluded?	**Yes ☐**	**No ☐**	**Treatment**

Other comments:

Reason for home visit:	**Access to property:**

Signature & Date: