

**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](http://www.lewis-manning.co.uk)

<b>1. ESSENTIAL PATIENT INFORMATION</b>		
Patient's Name	Patient's Address with Post Code	Telephone Number
Current location of Patient		Patient agrees to voicemail or answerphone messages being left Yes <input type="checkbox"/> No <input type="checkbox"/>
		Date of Birth
<b>2. REFERRED BY</b>		
Name and position	Contact number	Signature & Date
<b>3. PATIENT'S GP AND SURGERY</b>	<b>4. OTHERS INVOLVED</b> (name and phone number where possible)	
Telephone No: GP aware of referral Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Hospital Consultant(s)</li> <li>• District Nurses</li> <li>• Specialist Nurses</li> </ul>	
<b>5. CARER / SOCIAL HISTORY</b> (especially due to home visit)		
	Patient Aware Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Patient aware of end of life stage (when appropriate) Yes <input type="checkbox"/> No <input type="checkbox"/>	
Relevant surgery/treatment to date:		
History of swelling/onset/limb affected:		
Signs of Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Treatment
Evidence of Neuropathy	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Venous or Arterial insufficiency	Yes <input type="checkbox"/> No <input type="checkbox"/>	ABPI =
Has Thrombosis been excluded?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Treatment
Other comments:		
Reason for home visit:	Access to property:	
Signature & Date:		