

**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 701890
This referral form can be downloaded from the website: www.lewis-manning.co.uk

1. ESSENTIAL PATIENT INFORMATION		
Patients Name	Patients Address with Post Code	Telephone Number:
Date of Birth:		Patient aware of referral: Yes <input type="checkbox"/> No <input type="checkbox"/>
2. REFERRED BY		
Name and position	Contact number	Signature & Date
3. PATIENT'S GP AND SURGERY	4. OTHERS INVOLVED (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"> • Hospital Consultant(s) • District Nurses • Specialist Nurses 	
5. DIAGNOSIS	Patient Aware	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 of 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:		
Signature:		