

MORECAMBE BAY (CANCER RELATED) LYMPHOEDEMA REFERRAL FORM

Title and First Name	Surname	GP Name and Address
Home Details		Tel No
Street		Fax No
Town		
Post Code		
Tel No:		
NHS no.	D.o.b.	Consultant
Diagnosis:		Current Medication
Site of Lymphoedema:		
Relevant Surgery	Date	
Histology		Drug Allergies
Lymph Node Involvement		
Radiotherapy/Chemotherapy	Date	
Previous Medical History (particularly cardio-vascular conditions, diabetes)		
Diagnostic Investigations		Cancer Status at time of referral
• Venography	Y/N	• Active
• Doppler ultrasonography	Y/N	• Controlled
• MRI Scan	Y/N	• Metastesised
• Ultrasound Scan	Y/N	• Palliative
Referral Source:		Referral Date:
Referral Signature:		Lymphoedema Initial Consultation:

733225
 Tel No: 01539 735111; Fax No: 01539 ~~730000~~
 Email: denise.hardy@kendal-lymphology.org.uk