**Ashgate Hospice Lymphoedema Referral Form
Guidance:** Please complete all sections below.
Referral criteria can be found on our website.
Please return completed forms to the email stated below or Fax.

|  |  |
| --- | --- |
| **Ashgate Hospice**Ashgate RoadOld BramptonChesterfieldDerbyshire, S42 7JD | **Main reception:** 01246 568801 **Lymphoedema referrals email:** ashgate.lymphtriage@nhs.net**Fax:** 01246 565027**Website:** www.ashgatehospice.org.uk |
| **Date of referral:**  | **Time:**  |
| **Is the patient at home or currently an in-patient?** **If hospital, please state where: Tel:**  |

|  |  |
| --- | --- |
| **Referrer details**  | **GP/District Nurse Details** |
| Name: Job title: Contact numberEmail address: Base: | Named GP: Address: Postcode: Tel: District Nurse:Tel:  |

|  |
| --- |
| **Patient Details** |
| Patient’s name: Date of Birth:  NHS number:  Gender: Address: Postcode: Tel: Mobile: **Please state preferred contact number between 08:30 – 16:30:** **If the referral is accepted, would the patient be able to attend a clinic appointment? Yes/No** | Language spoken: Interpreter required? Yes/NoReligion: **Does the patient have a DNACPR in place?** Yes/No |
| **CONSENT**The information you share with us regarding the patient may be shared between other clinical services within the hospice and external services which may be beneficial to the care of the patient. Please specify below to confirm that the patient has consented to sharing information. **Has the patient consented to the referral?**Yes/No**Is the patient aware of the referral?**Yes/No |
| **Professional/Consultant involvement**Name: Location: Tel:  |
| **Next of Kin/Preferred Contact** |
| Name: Relationship to patient: Tel: Mobile: Address:  |

|  |
| --- |
| **Diagnosis details** |
| Does the Patient have a:[ ]  **Cancer/Life limiting illness** [ ]  **Non-cancer**  Please complete section A and B only Please complete section A and C only |
| **Section A**Diagnosis: Date of diagnosis: Metastases: Date of metastatic diagnosis: |
| **Past Medical History** | **Allergies** |
| **Current Treatment:** [ ] Curative[ ] Palliative **Please state:**  |

|  |  |
| --- | --- |
| **Section B: Cancer/Life limiting illness** Location of swelling: Onset of swelling (date): Current treatment/investigations i.e. chemo/scans etc: | **Section C: Non-cancer**Is this a Primary, Hereditary or Lipoedema diagnosis? Location of swelling: Onset of swelling (date): BMI: Does the patient have a family history of Lymphoedema? Yes/No |

|  |
| --- |
| **Reason for referral – please specify detailed reason for referral** Please send a copy of the GP summary, current medication, recent blood and scan results to process the referral |
|  |