**Referrals can be made by anyone as long as there is parental consent**

**Please complete all sections as much as possible**

|  |  |
| --- | --- |
| Name of parent (s)/carer(s): | Who holds parental responsibility? |
| Relationship to child/ young person: | Safe guarding information if applicable: | Language spoken at home: |
| Date of Birth: | Interpreter needed: Yes / No |
| Child / Young Person’s Name:  | Gender: M / F | Ambulance required: Yes / No |
| BMI: | H&C No: |
| Address:Postcode:Telephone: Mobile: | Protected address: Yes/ No |
| Name of school/ nursery/ preschool: |
| Patient’s GP:Surgery Address:  |
| Is the child/young person wheelchair/chair dependent? Yes/ No Further detail: |
| Is the child/young person housebound? Yes / No Further details: |
| **Lymphoedema History:**Area of Swelling: Duration of Swelling: Urgent - Lymphorrhea (Leaking) ⬜ No ⬜ Yes? Duration: Cellulitis: ⬜ No ⬜ Yes? Number of episodes in past 12 months: Past lymphoedema management:  | **Other Symptoms** [ ]  Heaviness [ ]  Pain [ ]  Lymphorrhea [ ]  Wound |
| **Medical Information:** Does the child / young person have any specific diagnoses?Surgery\* ⬜ No ⬜ Yes ⬜ N/A Procedure: If cancer Sx: Nodes removed: Yes / No? Number of +nodes:Chemo: Yes / No? Radiotherapy Yes / No? |
| **Medical History:** Yes No Yes No Yes NoHypertension [ ]  [ ]  Diabetes [ ]  [ ]  Venous Thrombosis [ ]  [ ] Heart Failure [ ]  [ ]  Obesity [ ]  [ ]  Chronic Skin Disorder [ ]  [ ] Phlebitis [ ]  [ ]  Varicose Veins [ ]  [ ]  Rheumatoid Arthritis [ ]  [ ]  Thyroid [ ]  [ ]  Sleep Apnoea [ ]  [ ]  Osteoarthritis [ ]  [ ] PVD [ ]  [ ]  Renal Failure [ ]  [ ]  Neurological Disorder  [ ]  [ ]  |
| **Advanced Disease at Referral:** ⬜ No ⬜ Yes |
| **Relevant Medication or please attach prescription drug / medication chart:**  |
| **Investigations to Date:** Lymphoscintigraphy [ ]  Carried out [ ]  OrderedDoppler [ ]  Carried out [ ]  OrderedPlease forward copy of results |
| **What support/ advice has the child/ young person received to date? (Please include any referrals to** **Paediatrician & Genetics etc)** |
| What difficulties is the child/ young person having? |
| What impact is this having at home/ school? |
| **Significant** |
| **None** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |
| **Level of parental concern** |  |  |  |  |  |  |  |  |  |  |  |
| **Level of referrer’s concern** |  |  |  |  |  |  |  |  |  |  |  |
| **Level of child’s concern** |  |  |  |  |  |  |  |  |  |  |  |
| **Further comments:** |

**History can continue on additional sheets if required**

|  |
| --- |
| Referrers Name **(PRINT):**  |
|  Designation: | Date: |
| Contact Address: | Contact Tel no  |

**ROUTINE**

Will be seen within

**4 weeks**