**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 No  Hypertension   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  Ordered  Doppler  Carried out  Ordered  Please 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**