**All Ireland Lymphoedema**

*Patient Sticker*

**Child & Young People**

 **Lymphoedema Review**

**Informed consent obtained** ⬜ No ⬜ Yes

If yes, and child under 16, consent provided by:

Relationship to child:

**Written consent obtained (for photographs)** ⬜ No ⬜ Yes

|  |  |
| --- | --- |
| Location of appointment: | Date of appointment: |
| Time of appointment: |
| Name of Therapist and Signature: |
| Name of people present: |
| What’s happened or any concerns since the last appointment |

**Any changes to medication?** ⬜ No ⬜ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any changes to medical history since last visit?** ⬜ No ⬜ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subjective Re-assessment**

**Pain:** (related to lymphoedema site)

Stated as: ⬜ Unable to determine ⬜ None ⬜ Mild ⬜ Moderate ⬜ Severe

Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Constant ⬜ Intermittent

Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (stabbing? burning? shooting? ache?)

**Pain score**

0 (nothing) 10 (excruciating)

**Heaviness:** ⬜ Unable to determine

**Heaviness score**

0 (nothing) 10 (excruciating)

**Sensation:** ⬜ Unable to determine ⬜ Normal

⬜ Altered Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cellulitis**

Any cellulitis since last seen: ⬜ No ⬜ Yes ⬜ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how many days off work/school due to cellulitis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main antibiotic given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the cellulitis cause hospital admission? ⬜ No ⬜ Yes ⬜ N/A

If yes number of nights as inpatient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prophylactic antibiotics? ⬜ No ⬜ Yes Date commenced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. of episodes within the last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if 2 episodes have prophylactic antibiotics been prescribed? ⬜ No ⬜ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Communication Function Classification System (CFCS)**

(Please tick boxes below or here if child too young or N/A)

* CFCS Level I – a person independently and effectively alternates between being a sender and receiver of information with most people in most environments
* CFCS Level II – a person independently alternates between being a sender and receiver with most people in most environments but the conversation may be slower
* CFCS Level III – a person usually communicates effectively with familiar communication partners, but not unfamiliar partners, in most environments
* CFCS Level IV – the person is not always consistent at communicating with familiar communication partners
* CFCS Level V – a person is seldom able to communicate effectively even with familiar people

**Gross Motor Function Classification System (GMFCS)**

****

****

****







**GMFCS Score**

*Patient Sticker*

**PROMS – Impact of Lymphoedema**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \* All the below questions relate to your **lymphoedema/vascular anomaly** | ☺None | 😐A little | ☹A lot | N/A |
| 1. Are you worried about your lymphoedema?\*
 |  |  |  |  |
| 1. Does your lymphoedema\* cause you pain?
 |  |  |  |  |
| 1. Do you have any problems moving your body?
 |  |  |  |  |
| 1. How much do your scars bother you?
 |  |  |  |  |
| 1. How much does the heaviness of your limb bother you?
 |  |  |  |  |
| 1. Are you worried about getting cellulitis (infection)?
 |  |  |  |  |
| 1. How much does the appearance of your lymphoedema\* worry you?
 |  |  |  |  |
| 1. Does your lymphoedema\* affect the clothes you wear?
 |  |  |  |  |
| 1. Does your lymphoedema\* affect the shoes you wear?
 |  |  |  |  |
| 1. Does your lymphoedema\* affect your hobbies?
 |  |  |  |  |
| 1. Does your lymphoedema\* affect you attending school/work?
 |  |  |  |  |
| 1. Does your lymphoedema\* affect relationships/friendships?
 |  |  |  |  |
| 1. Are you worried about wearing compression garments?
 |  |  |  |  |
| 1. Are you worried about your weight?
 |  |  |  |  |
| 1. Does your lymphoedema stop you doing any exercise?
 |  |  |  |  |

⬜ This is not applicable for this patient (please state reason)

Any other issues causing distress (in relation to lymphoedema)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using the scale shown with 0=none and 10=extremely 

How much knowledge do you have about lymphoedema/vascular anomaly?\_\_\_\_\_\_\_\_\_\_\_\_\_

How confident are to help your child in managing their lymphoedema/vascular anomaly? \_\_\_\_\_\_\_

**Objective Lymphoedema Reassessment**

**Skin Assessment**

**Active cellulitis today**? ⬜ No ⬜ Yes Antibiotics requested? ⬜ No ⬜ Yes ⬜ N/A

Prescribed: ⬜ No ⬜ Yes ⬜ N/A, if yes, prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Discolouration: | ⬜ No  | ⬜ Yes | Detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Temperature: | ⬜ Normal | ⬜ Cold |  ⬜ Hot |  |  |
| Shape: | ⬜ Normal | ⬜ Distorted | ⬜ Detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Blisters  | ⬜ No ⬜ Yes | Hyperkeratosis  | ⬜ No ⬜ Yes |
|  | Taut  | ⬜ No ⬜ Yes | Shiny  | ⬜ No ⬜ Yes |
|  | Ulcer/wound | ⬜ No ⬜ Yes | Lymphorrhoea | ⬜ No ⬜ Yes |
|  | Skin folds | ⬜ No ⬜ Yes | Fibrosis | ⬜ No ⬜ Yes |
|  | Fatty | ⬜ No ⬜ Yes | Fungal infection | ⬜ No ⬜ Yes |
|  | Eczema | ⬜ No ⬜ Yes | Rash | ⬜ No ⬜ Yes |
|  | Seroma | ⬜ No ⬜ Yes | Cording | ⬜ No ⬜ Yes |
|  | Papillamatosis | ⬜ No ⬜ Yes | Warts | ⬜ No ⬜ Yes |
| Haemosidirin staining | ⬜ No ⬜ Yes | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Tests** (please identify on body charts)

|  |  |  |  |
| --- | --- | --- | --- |
| Pitting Test |  | ⬜ Positive | ⬜ Negative |
| Stemmers sign: | ⬜ Positive | ⬜ Negative |
| Pain at night or at rest: | ⬜ No  | ⬜ Yes  | ⬜ N/A |
| Intermittent claudication: | ⬜ No  | ⬜ Yes  | ⬜ N/A |
| Capillary refill: \_\_\_\_\_\_\_\_\_\_\_ |  (normal is < 3 sec) |
| Blanching on elevation:  | ⬜ No | ⬜ Yes  | ⬜ N/A |
| Vascular assessment required:  | ⬜ No  | ⬜ Yes  | ⬜ N/A |

**Range of Movement (ROM)**

|  |  |  |
| --- | --- | --- |
|  | **RIGHT** | **LEFT** |
|  | **100%** | **75%** | **50%** | **25%** | **0%** | **100%** | **75%** | **50%** | **25%** | **0%** |
| Shoulder | Hip |  |  |  |  |  |  |  |  |  |  |
| Elbow | Knee |  |  |  |  |  |  |  |  |  |  |
| Wrist | Ankle |  |  |  |  |  |  |  |  |  |  |
| Fingers | Toes |  |  |  |  |  |  |  |  |  |  |
| Functional Impact: |

Were circumferential measurements captured & recorded?⬜ No ⬜ Yes, reason why not \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was weight captured & recorded? ⬜ No ⬜ Yes, reason why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was height captured & recorded? ⬜ No ⬜ Yes, reason why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was BMI captured & recorded? ⬜ No ⬜ Yes, reason why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consider growth percentile changes:

**Body Chart**

*Patient Sticker*

|  |
| --- |
| **Photo taken:** |
| ⬜ No | ⬜ Yes |

|  |
| --- |
| **Reassessment findings:** |
| **What are the therapist’s main concerns/issues today?** |
| **What are the child’s/ young person’s goals/hopes/aspirations?** |
| **What are the parent/ carer goals/hopes/aspirations?** (if applicable) |
| **Agreed combined goal:** |

**Education, Advice and Lymphoedema Care Plan**

**Education, Advice and Lymphoedema care Plan**

*The patient/parent/carer has agreed to continue with the following actions:*

⬜ Skin care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⬜ Movement/exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Compression garment required: ⬜ No ⬜ Yes; Details of garment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was garment: ⬜ provided or ⬜ ordered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⬜ Compression advice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⬜ Weight/Lifestyle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_⬜ Simple Lymphatic Drainage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intensive Treatment: Please tick if the following is needed**

⬜ Decongestive Lymphatic Therapy ⬜ Multi-Layer Lymphoedema Bandaging ⬜ LymphAssist

⬜ Manual Lymphatic Drainage ⬜ Manual Therapy/Scar Management

⬜ Electrotherapy (Physiotouch/Oscillator/Laser)

**Detail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral to other service required? ⬜ No ⬜ Yes to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completed? ⬜ No ⬜ Yes

Letter to patient/parent/carer copying in GP: ⬜ No ⬜ Yes, if No reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information Given:**

LNW leaflets issued ⬜ No ⬜ Yes; LNW video links issued ⬜ No ⬜ Yes

**Outcome of Lymphoedema Review**

Patient discharged. ⬜ No ⬜ Yes, Discharge code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no what is the agreed timeframe to be seen again within?

⬜ Within 6 months ⬜ Within 12 months ⬜ Book in for Intensive Treatment

**Factors Affecting the Outcome of Treatment**

Vascular complications ⬜ No ⬜ Yes Mobility problems ⬜ No ⬜ Yes

Lack of support ⬜ No ⬜ Yes Recurrent cellulitis ⬜ No ⬜ Yes

Pain ⬜ No ⬜ Yes Progressive co-morbidities ⬜ No ⬜ Yes

Excess body weight ⬜ No ⬜ Yes Cognitive impairment ⬜ No ⬜ Yes

Ability to don/doff garments ⬜ No ⬜ Yes Sedentary lifestyle ⬜ No ⬜ Yes

Functional problems ⬜ No ⬜ Yes Chronic skin condition ⬜ No ⬜ Yes

Psychosocial ⬜ No ⬜ Yes Sleeping in chair ⬜ No ⬜ Yes

**LNW Outcome**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ⬜ 1 At Risk  | ⬜ 2 Mild | ⬜ 3 Moderate | ⬜ 4 Severe | ⬜ 5 Complex | ⬜ 5W Complex  with wound |

**ISL Grouping**

⬜ Stage 0 ⬜ Stage 1 ⬜ Stage 2 ⬜ Stage 3

 *(Latency)* *(mild/pitting) (Moderate/non-pitting) (Complex/fibrosis/skin changes)*

**BLS Grouping**

|  |  |  |  |
| --- | --- | --- | --- |
| **Group 0** – *Latent (at high risk)* |  | **Group 3.1** – *Complex LO: one limb* |  |
| **Group 1** – *Early Lymphoedema* |  | **Group 3.2** – *Complex LO: multiple limbs*  |  |
| **Group 2** – *Uncomplicated (established) LO* |  | **Group 3.3** – *Complex midline LO* |  |
|  |  | **Group 4** - *Palliative* |  |

**Print Name:** **Date:** \_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature:** **Time:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Time in units(TIU) |  | TIU total: |  | Total number of treatments: |  | Date of next appointment: |  |

*Patient Sticker*

|  |
| --- |
| **Actions & Communications Since Last Appointment** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |