Lymphoedema Service
Dewsnap Lane Clinic Dewsnap Lane
Dukinfield CHESHIRE SK16 5AW
Tel: 0161 366 2135 - Fax: 0161 366 2355

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Lymphoedema/Chronic Oedema Services

Title: Mr/Mrs/Ms/Miss Forename:…………………................................... Surname: .... Address:…………………………………………………….......... ………………………….............. Post Code: …………………… Tel: .... Mobile:	GP Name:... GP Address ……………………………………………………........ ….. Post Code:……………………................. Tel:………………………............................. Fax:……………………..............…................

Date of Birth: _ _ /_ _ / _ _ _ _ NHS No: _ _ _ _ _ _ _ _ _ _

Reason For Referral

□ Oedema □ Lymphoedema Area/s of Swelling:

Has the swelling been more than 3 months duration? □ Yes □ No

Does the swelling reduce following resting overnight? □ Yes □ No

Medical History (GP Referrals, please include Medical Summary Sheet)

□ Diabetes □ DVT □ Vascular Disease □ Hypertension □ Kidney Disease □ Heart Problems

□ Rheumatoid Disease □ Chronic Skin problems □ Hemiplegia □ Thyroid Problems □ Psychosocial

Does the patient currently have a wound? □ No □ Yes – please use District Nurse/TVN Referral Form

Is the patient undergoing or have a history of treatment for cancer?

□ No □ Yes – please give details of treatment received ………………………………………………………

Does the patient have any allergies?
□ No □ Yes (please give details): ....

Current Medication

It is essential that a copy of the Medication/Medical History is attached (if not included referral will be returned)

□ **YES I have attached a copy/list of the prescribed medication/brief medical summary**

□ **The patient does not take any prescribed medication**

Referrer details: (complete in full)

Name: Signed:

Base/Contact Number: Date:

Please send completed forms to:
Lymphoedema Service, Dewsnap Lane Clinic, Dewsnap Lane, Dukinfield, SK16 5AW
Fax: 0161 366 2355 or Email tga-tr.complexwounds@nhs.net