**Hospital Street Doctors Lymphoedema clinic**

**Referral Form**

**Email this form to: lymph.care@hospitalstreetdoctors.com.au**

Urgent referrals please phone: 02 60561166 and ask to speak with Dr. Pushkara Epa

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| **Referrer Details** |
| Name:  Practice Name:  Practice Address:  Phone:  Email: |
| **Patient Details** |
| Name:  Date of Birth:  Address:  Best contact phone:  Email:  Interpreter Required: □ No □ Yes - Language:  Medicare No:Expiry date:  Commonwealth Pension/healthcare card No:  Private Health Insurance:  TAC/Work Cover: □ Yes □ No |
| **Reason for Referral** |
| **Past Medical History (please attach health summary)** |
| **Relevant Medical History**  ☐ Pitting oedema ☐ Non-pitting oedema  ☐ Smoker ☐ Non-Smoker  Weight: \_\_\_\_\_\_\_kg Height: \_\_\_\_\_\_\_cm \***NB: Referrals without this information cannot be triaged**  **Prior cancer/s (include type & diagnosis date):**  **Prior treatment for cancer (surgery/chemotherapy/radiotherapy/hormone therapy) including hospital/doctor details & dates:**  **Previous treatment for lymphoedema**  Type of treatment:  Practitioners:  **Current problems/issues related to lymphoedema**  ☐ Swelling ☐ Ache ☐ Infection ☐ Impaired function ☐ Other: |
| **Current Medications and Dosage ( please include in health summary)** |
| **Allergies** |
| **Relevant investigations – please attach results to avoid delays in care for patient**   1. Blood test results: U&E, LFT, FBE, TSH, CRP, HbA1c (required for all patients) 2. Recent letter from Oncologist/Surgeon from last 12 months (if relevant) 3. Anatomical pathology from prior cancer-related surgery (if relevant) 4. Duplex scan from last 6 months (for patients with lower limb oedema only) 5. Ultrasound scan (required for scrotal/genital oedema)   **For patients with history of cancer and recent onset of lymphoedema (within last 6 months) – please refer back to Oncologist/Surgeon to exclude recurrence** |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_