Cornwall Hospice Care
Caring for our community

CORNWALL HOSPICE CARE

LYMPHOEDEMA REFERRAL FORM

Name of referrer	**Designation**
Date	
Name of patient	
Address **Telephone**	
Date of birth	**Hospital number**
G.P. **Practice**	
Surgeon	**Oncologist**
DIAGNOSIS	
Date of diagnosis	
Surgery (procedures & dates)	
Chemotherapy (regime & date)	
Radiotherapy (site & date completed)	
Current treatment:	
Current disease status: **Inactive** **Controlled progressive** **Palliative**	
REASON FOR REFERRAL: **Site of lymphoedema**	
Lymphoedema has been present for:	
Additional information:	