Please complete all details to ensure your referral is not delayed

Jersey Hospice Care
your care, your choice, your time

Fax: 01534 720292
Please ensure both sides are faxed.
Post: Lymphoedema Clinic, Clarkson House, Mont Cochon, St Helier, JE2 3JB

EXTERNAL LYMPHOEDEMA CLINIC REFERRAL FORM

1. Patient Details

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ADDRESSOGRAPH

Title:_______________DOB:_______________
Surname: ______________________________
Forenames: ______________________________
Address: ______________________________
____
_______________Post code_________
Urn: _______________Index No:_______________
Tel No:_______________Mobile No: _______________

2. GP Details

Name:	
Surgery address and post code	
Telephone no:	

3. Referrer:

Name:______________________________Designation:______________________________
Telephone No:______________________________Date:______________________________

4. Where is the patient at present:

Home ☐ Hospital ☐ Nursing Home ☐
Residential Home ☐ Other:

5. Drug allergies and sensitivities: (describe reaction)

6. Reason for referral/Current problems

7. Diagnosis: including current cancer status, any local recurrence, distant metastases and lymph node involvement.

8. Past and present relevant procedures and treatments: Including surgery, radiotherapy, chemotherapy, investigations for DVT.

9. Co-morbidities: e.g. heart failure, hypoabuminemia

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10. What is the patient's overall Australian Karnofsky Performance Status		**Please tick**
100%	Normal, no complaints, no evidence of disease	☐
90%	Able to carry on normal activity, minor signs or symptoms of disease	☐
80%	Normal activity with effort, some signs or symptoms of disease	☐
70%	Cares for self, but unable to carry out normal activity or to do active work	☐
60%	Able to care for most needs, but requires occasional assistance	☐
50%	Considerable assistance and frequent medical care required	☐
40%	In bed more than 50% of the time	☐
30%	Almost completely bedfast	☐
20%	Totally bedfast and requiring extensive nursing care by professionals and/or family	☐
10%	Comatose or barely rousable, unable to care for self, requires equivalent of hospital care, disease may be progressing rapidly.	☐

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11. Awareness of:

	Patient		
Diagnosis	Yes ☐	No ☐	Don't know ☐
Prognosis	Yes ☐	No ☐	Don't know ☐
Referral	Yes ☐	No ☐	Don't know ☐

NB: To process the referral without delay please ensure you fax both sides of the form and send the following:

- Copies of hospital correspondence
- Medication summary
- Past medical history
- Significant letters

For Hospice Use Only – this must be completed for every referral received		
Date referral received :		
Dr. contacted for agreement.	Yes ☐ No ☐	Date:
Dr. has given agreement	Yes ☐ No ☐	Date:
Date patient contacted:		
Date patient seen:		