Sheffield NHS
Primary Care Trust

WE ARE MACMILLAN. CANCER SUPPORT

Sheffield Macmillan Lymphoedema Service

CRITERIA FOR REFERRAL

Referrals to the service are accepted from medical staff, qualified nurses, physiotherapists, occupational therapists and speech and language therapists

Referrals should be made either by letter or using the service referral form available on the Intranet, having considered the following criteria:

- This service is for patients registered with Sheffield GP's
- Patients have a diagnosis of cancer related lymphoedema with no immediate contraindications to lymphoedema management ie

  → Suspected recurrent disease prior to confirmation
  → Untreated Heart Failure
  → Hypoproteinaemia
  → Untreated Infection/Cellulitis
  → Untreated Deep Vein Thrombosis (DVT)
  → Hypothyroidism

- Patients have a non-cancer related trunk or limb swelling

Please be aware that where obesity is the cause of lymphoedema, the patient must be willing to embark on a weight loss and exercise programme to be eligible for a lymphoedema management programme

Please let us know if this is an urgent palliative referral.

If you have any queries regarding your referral, please contact –

Sheffield Macmillan Lymphoedema Service
Fairlawns Middlewood Medical Centre
621 Middlewood Road Sheffield S6 1TT
Tel: 0114 232 0689 Fax: 0114 229 2949

Sheffield Macmillan Lymphoedema Service
Referral Form

Title Mr Mrs Miss Ms Other **Patient name:** **Address** **Contact Tel No** **DOB** **NHS No** **Does patient consent to referral? Y / N**	**Patient's GP** Address: **Referrers name** Contact details: Designation: Print: Signed Date

Height: Weight: Area of body affected:

Is this a palliative referral ie urgent? Y / N

Lymphoedema type: Cancer –related Non-cancer-related

If cancer related : Diagnosis and date and type of surgery

Relevant Medical History

Current medication (if extensive please enclose print out)

Additional information/ Previous treatment:

Is an interpreter required? Y / N If Y which language? ……

Please let us know if transport might be a problem.

Office use only
Patient number……. Date Referral received: ……. Date of First visit