

**Calgary Ambulatory Lymphedema
(CALs) Referral**

| | | | |
|---|--|---|--|
| Last Name <i>(Legal)</i> | | First Name <i>(Legal)</i> | |
| Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First | | DOB <i>(dd-Mon-yyyy)</i> | |
| PHN | ULI <input type="checkbox"/> Same as PHN | MRN | |
| Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown | |

For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca

| Referral Information | | | |
|---|---|--|---|
| Diagnosis | | Date of Onset <i>(dd-Mon-yyyy)</i> | |
| <input type="checkbox"/> Primary Lymphedema <input type="checkbox"/> Secondary Lymphedema | | | |
| Body Part(s) affected | | | |
| Other Details | | | |
| <input type="checkbox"/> BMI _____ | | | |
| Relevant Treatment to Date <i>(Medications, Compression Therapy, Education)</i> | | | |
| Potential Contraindication to Compression Therapy <i>(Check all that apply)</i> | | | |
| <input type="checkbox"/> Abnormal renal function | | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Deep Vein Thrombosis (DVT) |
| <input type="checkbox"/> Congestive Heart Disease | | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> I confirm this patient is medically stable and safe for prolonged compression therapy. | | | |
| Factors that may impact prioritization of assessment <i>(check all that apply)</i> | | | |
| <input type="checkbox"/> History of recurrent cellulitis <i>(provide approximate dates)</i> _____ | | | |
| <input type="checkbox"/> Wounds | | | |
| Currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <input type="checkbox"/> Employment affected | | | |
| Referral Source Information | | | |
| Referring Provider | | Phone | Fax |
| Family Physician | <input type="checkbox"/> Same as Referring Provider | Phone | Fax |