Lymphedema Addendum – Assessment/Evaluation Form

(to be completed by practitioner at time service)

Name: _____ **DOB:** _____ **Age:** _____

Occupation: _____ **Currently Working:** ☐ **Yes** ☐ **No**

Referred by: _____ **Phone #:** _____

Primary lymphedema physician or PCP: _____

Primary Lymphedema Therapist (CLT): _____

Diagnosis: _____

Clinical Presentation:
(check all that apply)

☐ **Lymphedema** _____
☐ **Lipedema** _____
☐ **CVI** _____
☐ **Cardiac edema** _____
Stemmer sign ☐ (+) ☐ (-) ☐ Fingers ☐ Toes

Height: _____
Weight: _____ **(lbs) BMI:** _____

BMI = Weight x 703 / height^2 in inches
Normal = 18.5 – 24.9, overweight > 25, obese > 30

Triggering event and start date of swelling/lymphedema: _____

_____

Chief complaint: _____

_____

Client goals: _____

_____

Cellulitis? ☐ Yes ☐ No Notes: _____

Pain? ☐ Yes ☐ No Notes: _____

Contraindications ☐ General ☐ Neck MLD ☐ Abdominal MLD ☐ N/A

Notes: _____

Previous treatment for swelling/lymphedema? ☐ Yes ☐ No

If yes, check all that apply:

☐ Manual Lymph Drainage (MLD)	☐ Compression pump	☐ Compression garments
☐ Compression bandaging	☐ Elastic taping	☐
☐ Lymphedema exercise	☐ Low level laser	☐

Notes: _____

_____

_____

Does client currently wear a compression sleeve or stocking? ☐ Yes ☐ No

Notes: (include frequency of use and age of garment) _____

Does client currently use compression at night? ☐ Yes ☐ No

Notes: _____

Does client exercise regularly? ☐ Yes ☐ No

Notes: _____

Is client familiar with the National Lymphedema Network? ☐ Yes ☐ No

Is client familiar with the precautions (risk reduction practices) for Lymphedema? ☐ Yes ☐ No

Is client a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No

Additional observations: _____

_____

_____

_____

_____

TREATMENT PLAN

☐ Manual Lymph Drainage (MLD)

_____

_____