

# Lymphoedema application form 2025



## Contact us

Tel: 0800 12 CARE (2273) • PO Box 653418, Benmore 2010 • www.libcare.co.za

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## Contact us

For any queries, please email [oncology@libcare.co.za](mailto:oncology@libcare.co.za) or contact Libcare Contact Centre on **0800 12 CARE (2273)**, Mondays to Fridays from 8:00 to 17:00 (excluding public holidays).

## Purpose of the form

This application form is for members that need oncology related lymphoedema (secondary to cancer) treatment. We will only consider funding requests from the member's treating healthcare professional, who must complete the application form.

## What you must do

- Please print clearly using CAPITAL letters and one character per block.
- All relevant sections must be physically signed by the healthcare professional and cannot be signed digitally. The healthcare professional must sign and date any changes.
- Please send the form and photographs to us by email at [oncology@libcare.co.za](mailto:oncology@libcare.co.za).
- Only applications that have been completed by healthcare professionals will be accepted.
- You will receive a letter informing you of our decision and what to do next for approved requests. You may call us if you would like to lodge a formal dispute for a declined decision. If you have any questions, you can call our call centre on 0800 12 CARE (2273), Mondays to Fridays from 8:00 to 17:00 (excluding public holidays).

## 1. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>		
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <input type="text"/>
SA ID/Passport number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
E-mail address	<input type="text"/>		
Referring practitioner's name	<input type="text"/>		
BHF practice number	<input type="text"/>		
Primary diagnosis	<input type="text"/>		

Current location of swelling



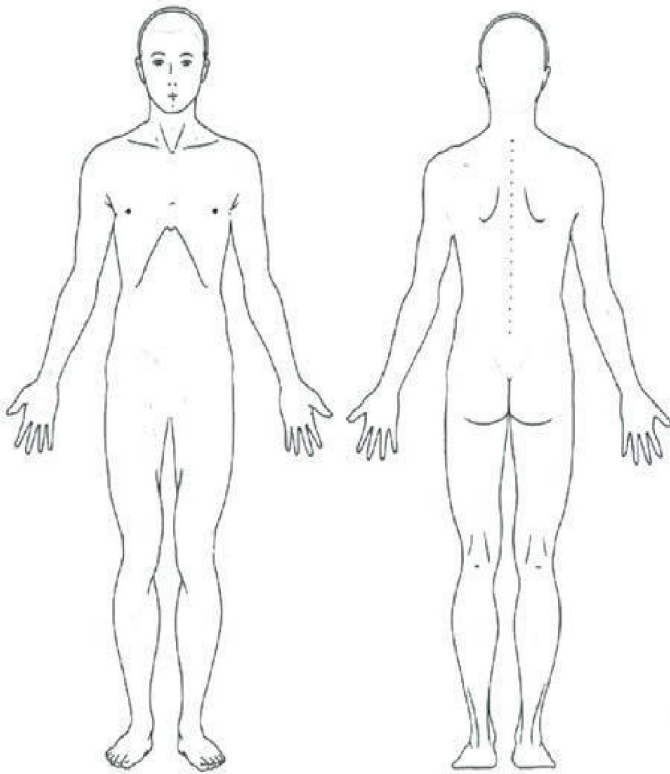
Swelling



Pitting



Tissue thickening



Limb circumference measurements

	Upper limb		Lower limb	
	R	L	R	L
Hand/foot circumference (cm)				
Starting point (cm)				
Above elbow/knee (cm)				
Below elbow/knee (cm)				
Total limb volume (ml)				
Distal volume (ml)				
Proximal volume (ml)				
Distal:proximal ratio				
Excess total limb volume (ml and %)				
Excess distal limb volume (ml and %)				
Excess proximal limb volume (ml and %)				

2. Lymph node Status

Regional node dissection  Yes  No If yes, state region:

Sentinel lymph node biopsy  Yes  No

Chemotherapy  Yes  No  Still to be decided

If yes  Adjuvant  Neoadjuvant  Oral

Radiation therapy  Yes  No  Still to be decided  Still due for radiology

If yes, state area

3. Existing medical conditions and co-morbidities

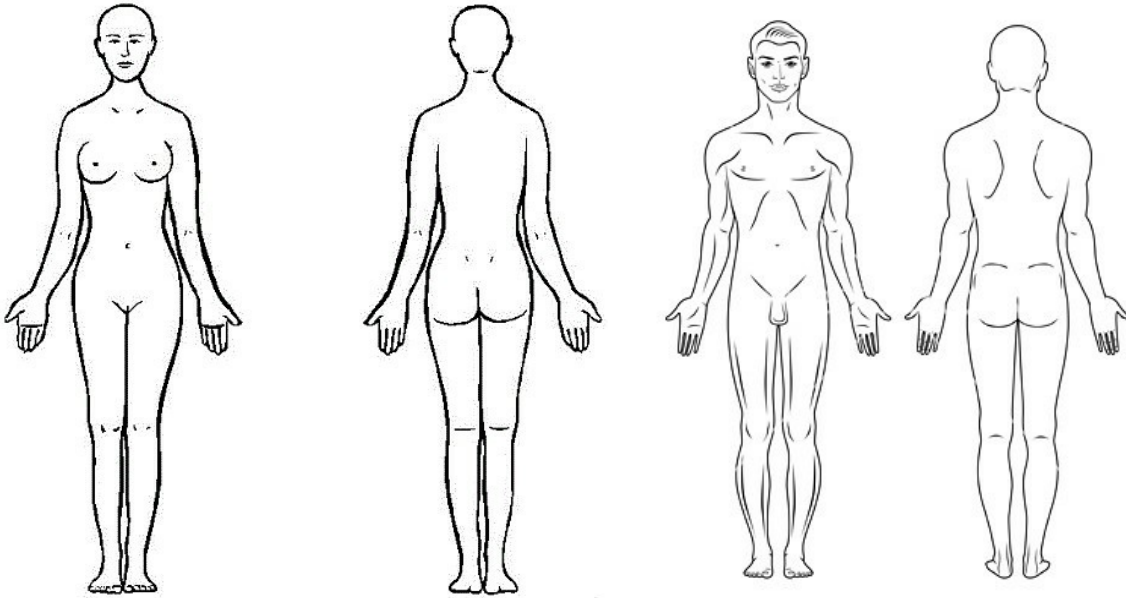

#### 4. Any factors that may complicate, influence or affect prognosis for lymphoedema treatment

(If more space is required, please describe on a separate letter attached to this motivation.)


#### 5. Previous Lymphoedema Treatment (include nature of treatment and duration)


#### 6. Limb Circumference Measurements (in cm)

Upper limb:	Right	Left	Lower limb:	Right	Left
Index finger			Big toe		
Thumb			Metatarsophalangeal		
Metacarpophalangeal			Mid-foot		
Distal wrist crease			Ankle		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Elbow			Knee		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Total limb vol:			Total limb vol:		
Excess total limb vol (%):			Excess total limb vol (%):		



### 7. Proposed Treatment

Lymphoedema therapist

BHF practice number

Staging  Date of staging

Treatment start date

### Initial consultation

Requested code	Cost

### Treatment

Requested code	Cost	Frequency	Motivation

### Garments and bandages

NAPPI code	Cost	Quantity	Description

**8. Total cost of proposed treatment**

Initial visit									
Treatment plan									
Garments and bandages									
Total cost of proposed treatment									
Signature of health professional	Date <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		



Please only sign if information is true, complete and correct.