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v1.00 - 05/2011

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Children's Health Queensland Hospital and Health Service

Oedema Measurement Form

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Left Lower / Upper Limb Affected / Unaffected				Measurements (cm)	Right Lower / Upper Limb Affected / Unaffected			
				Date				

OEDEMA MEASUREMENT FORM

Name ..... DOB ..... UR No .....

Left Lower / Upper Limb Affected / Unaffected				Measurements (cm)	Right Lower / Upper Limb Affected / Unaffected			
				Date				

DO NOT WRITE IN THIS BINDING MARGIN