Form Date: 2025/12/12

London Health Sciences Centre

Epilepsy Referral Form

Fax completed form to 519-663-3204

The Epilepsy Program only accepts referrals for refractory epilepsy, (i.e., patients who continue to have seizures despite adequate trial of two anti-seizure medications). These patients will not be accepted: First seizure, Provoked seizures, Acute symptomatic seizures, Urgent cases, Epilepsy adequately controlled on anti-seizure medication, Outside catchment area (see website for details).

Patient Information

First Name:

Last Name:

Middle Initial:

Preferred Name:

Address:

City:

Postal Code:

Preferred Phone Number:

Email:

Patient consents to appointment information being shared via text message or email:

Yes (text): ☐ **Yes (email):** ☐

Date of Birth:

Health Card Number (HN):

Version Code:

WSIB Claim Number:

Other (Self pay, research or third party):

Sex Assigned at Birth: Female: ☐ **Male:** ☐

Interpreter Required (Yes/No):

Language Required:

Accessibility Needs:

First Available Appointment: ☐ **Request Physician:** ☐

Requested Physician's Name:

**Wait times may vary by physician. A specific physician request may result in a longer wait tine for the patient.*

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Patient History

When did the patient start having seizures?

What anti-seizure medications has the patient been on?

Provide the following: 1 - Previous EEG and MRI reports, 2 - Genetic and/or neuropsychology testing (if available)

Referring Provider:

Provider Name:

Billing Number:

Professional ID:

Address:

City:

Province:

Postal Code:

Phone Number:

Fax Number:

Copy To:

Provider Signature:

Referral Date: