Form Date: 2025/09/10

London Health Sciences Centre

First Seizure Clinic Referral Form

Fax completed form to 519-663-3204

The First Seizure Clinic will **NOT** accept patients who are already started on anti-seizure medications, have a diagnosis of epilepsy, are outside catchment area (see website for details), are already followed by a neurologist, have provoked seizures (those caused by alcohol withdrawal, drug misuse, metabolic or electrolyte abnormalities, etc.)

Patient Information

First Name:

Last Name:

Middle Initial:

Preferred Name:

Address:

City:

Postal Code:

Preferred Phone Number:

Email Address:

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

☐ **Yes (text)** ☐ **Yes (email)**

Date of Birth:

Health Card Number (HIN):

Version Code:

WSIB Claim Number:

Other (Self pay, research or third party):

Sex assigned at birth:

☐ **Female** ☐ **Male**

London Health Sciences Centre

Interpreter Required:

☐ **Yes** ☐ **No**

Language Required:

Accessibility Needs:

Patient History

Referring Provider

Provider Name:

Billing Number:

Professional ID:

Address:

City:

Province:

Postal Code:

Phone Number:

Fax Number:

Copy To:

Provider Signature:

Referral Date: