Children's Hospital
London Health Sciences Centre

PAEDIATRIC EPILEPSY MONITORING UNIT (EMU)

IMPORTANT: TO ENSURE TIMELY PROCESSING PLEASE FAX COMPLETED REFERRAL FORM WITH ANY RELEVANT CLINIC NOTES TO (519) 685-8350

TODAY'S DATE:____

PATIENT NAME____ **DOB (YY/MM/DD)**______________________

HEALTH CARD NUMBER___________________________________ **DEVELOPMENTAL AGE** ________________

ADDRESS____ **PHONE**______________________________

CITY____**POSTAL CODE**____________________________________

PIN #____ **EMAIL**________________________________

Medical History (brief seizure history, description of events)

____

____

____

____

Reason for EMU admission (circle one) **Surgical** **Diagnosis** Is this referral URGENT? **YES or NO**

Requested length of stay: _______ days Previous EMU admission? **Yes or No** Date:________________________

Current Medications: ____Weight: ____________________

____

____

Previous epilepsy medications:____

Other medical conditions:____

Prior EEG? **Yes or No** Date(s): ____

Prior MRI of brain? **Yes or No** Is MRI organized along with EMU admission? **Yes or No**

Will patient keep electrodes in place for several days? **Yes or No**

Is patient aware of referral? **Yes or No** If No, please explain____

Referring Provider ____

Address ____

____

Phone Number ____

Fax Number ____

FOR OFFICE USE ONLY

☐ *Date received*______________________ ☐ *Letter mailed* _________________ ☐ *Family notified*_______________________

Paediatric Neurology 800 Commissioners Rd East London ON N6A 5W9Tel (519) 685-8332 Fax (519) 685-8350