

August 2019

Paediatric Neurology First Seizure Clinic Referral Form

Children's Hospital
London Health Sciences Centre



Indications for Referral

- First afebrile/unprovoked seizure
- Recurrent febrile seizures
- New suspected diagnosis of Epilepsy (If confirmed, will be followed by in general/Epilepsy clinic)

DATE OF REFERRAL:	REQUESTING PRACTITIONER:
CHILD'S NAME:	OFFICE ADDRESS:
PATIENT DATE OF BIRTH:	
PATIENT ADDRESS:	OFFICE TELEPHONE NO.
PATIENT PHONE NUMBER:	OFFICE FAX NO.
Will an interpreter be required?	Language:

This referral is: Urgent Non-urgent
 Referral if from: LHSC-ER Pediatrician Family doctor Nurse-practitioner Other: _____
 Is the patient aware of the referral? YES NO

Event Description

- Is seizure the most likely diagnosis? Yes No, And if no please specify: _____
- What kind of seizure was observed? Generalized Focal Unknown
 - If generalized, please identify: Tonic-clonic Absence Myoclonic Atonic Unknown
 - If focal, please identify: Focal motor Focal non-motor Unknown Other: _____
 - Please provide a brief seizure description: _____
- Epilepsy risk factor: Family history febrile seizures Developmental delay/autism History of Head Trauma/infection
- Seizure onset <3 months >3 months
- Frequency of events: One 1-10 seizures > 10 seizures
- Circumstances of the seizure: Unprovoked breath-holding Feeding Infectious Other: _____
- Neurological Exam: Normal Abnormal, If abnormal, please specify: _____

Clinical tests:

- Has EEG been ordered? Yes No If YES: Provide Date and location of EEG _____
If available, describe EEG Result _____
- Diagnostic Imaging completed: Yes No Date/Results: _____
- Anti-seizure medication?: Yes No, If yes, please indicate: _____
- Psycho/emotional co-morbidities: Depression Anxiety Other _____
- Other medications: List name, dosage and how long taking: _____
- Is the patient driving? Yes No, if yes has MTO been informed? _____

Post-encounter impression: Seizure Yes No EEG indicated: Yes No Follow up arranged: Yes No _____