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| **First Seizure Clinic Referral Form**  **Please attach to eReferral** | | | | |
| **GP STAMP (name, address & phone number)** | **Name of Hospital** | | | |
| **ED** | **MAU** | **Other Department** | |
| **Name of referring consultant team and contact phone number:** | | | |
| **Patient details**  **Name:**  **Sex:**  **D.O.B:**  **Address:**  **Tel. No:**  **Carer’s name:**  **Carer’s Tel. No:** | **Date of referral:** | | | |
| **Interpreter needed Yes/No**  **Language?** | | | |
| **Date of seizure:** | | | |
| **Patient history** | **Current drug therapy:** | | | |
| Please ask a witness to come with the patient to clinic or provide phone contact details here if this is not possible: | | | |
| **Referral Guidelines** | | | | |
| Above 16 years old | | | |  |
| New onset seizures or blackouts **(Syncope should not be referred)** | | | |  |
| Patient has made a full recovery from event | | | |  |
| Not under a neurologist for seizures/blackouts (please refer back to the team involved) | | | |  |
| Patient information sheet given out | | | |  |
| **For patients referred from hospital settings** | | | |  |
| Bloods exclude infection or metabolic derangement | | | |  |
| Imaging (CT or MRI) excludes a space occupying lesion (please discuss acute management with the appropriate specialty) | | | |  |
| ECG normal | | | |  |