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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 |  |