|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referring For:** | | **Referring Consultant** | | |
| Patient Name |  | Consultant Name | |  |
| DOB |  | Referring Hospital | |  |
| NHS Number |  | Consultant Email/phone | |  |
| Address |  | Test type | Choose an item. | |
| Postcode |  | Urgent? | Yes  No | |
| Parent Telephone |  | Urgent Reason | Choose an item. | |
| Parent Email |  | Other (specify) |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reason for referral** | | | | |
| Clinical question |  | | | |
| Diagnosis |  | | | |
| Clinical Summary | please *also include birth/developmental history and any* ***access requirements*** *or* ***accommodations*** *we should be aware of before the appointment.* | | | |
| Description of events and current frequency | 1 |  | | |
| 2 |  | | |
| 3 |  | | |
| Current medication | *parents to bring a supply of emergency medication if appropriate.* | | | |
| Any recent medication changes |  | | | |
| Imaging |  | | | |
| Previous EEGs |  | | | |
| Melatonin (if required) | 2mg for children under 3 years. 3mg under 6 years. 6mg for over 6 years. ***Please note Melatonin will need to be prescribed and dispensed by you beforehand so that parents can bring it to the EEG appointment*** | | | |
| **Requesting Doctor Signature** |  | | **Date** |  |

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| --- |
| **Please email the completed form and any additional information to:** |
| Diagnostic Suite – EEG Department  Young Epilepsy, Neville Childhood Epilepsy Centre, St Piers Lane, Lingfield, Surrey, RH7 6PW  [youngepilepsy.diagnostics@nhs.net](mailto:youngepilepsy.diagnostics@nhs.net) 01342 831273 |