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| **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) |  |

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| **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 DepartmentYoung Epilepsy, Neville Childhood Epilepsy Centre, St Piers Lane, Lingfield, Surrey, RH7 6PWyoungepilepsy.diagnostics@nhs.net 01342 831273 |