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

EEG referral form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Reason for referral | | | | |
| Clinical question |  | | | |
| Diagnosis |  | | | |
| Clinical Summary | please *also include birth/developmental history* | | | |
| 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 |  |

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