FIRST SEIZURE OUTPATIENT REFERRAL FORM

FAX NUMBER: 021 4922667

Patient ID

Date of referral:

Date of event:

Referring department: Emergency Dept. CUH

Referring Consultant:

Patient contact number: Mobile Landline

Collateral Hx Name: Contact number:

Details of event: (prodrome, witnessed/unwitnessed, duration, tongue biting, incontinence, post-ictal):

Relevant past medical history:

Family history:

Social History:

MRI: booked Yes ☐ No ☐
Any available imaging results:

EEG: booked Yes ☐ No ☐
Any available results

Started on Keppra: Yes ☐ No ☐

Other medication details

Driving/swimming/heights advice given: Yes ☐ No ☐ Patient Occupation:

Any other relevant information:

Signed Contact number/bleep: