

EEG referral form

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 <input type="checkbox"/> No <input type="checkbox"/>
Parent Telephone		Urgent Reason	Choose an item.
Parent Email		Other (specify)	
Reason for referral			
Clinical question			
Diagnosis			
Clinical Summary	<i>please also include birth/developmental history</i>		
Description of events and current frequency	1		
	2		
	3		
Current medication	<i>parents to bring a supply of emergency medication if appropriate.</i>		
Any recent medication changes			
Imaging			
Previous EEGs			
Melatonin (if required)	<i>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</i>		
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 01342 831273			