Referral Form: Diagnostic Suite – EEG Department

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**

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 01342 831273