Hamilton Health Sciences

GENERAL SITE - EPILEPSY TEAM
SERVICES - NEUROSCIENCES
AMBULATORY CLINIC (NAC)
ADULT EPILEPSY CLINIC REFERRAL

Phone - 905-527-4322 ext. 44986 / Fax - 905-527-0059

Patient's Last Name First Name

Address Street

City

ID Number HIN

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Family Physician

The purpose of the Epilepsy Clinic is to provide rapid access to consultation and diagnostics for adult patients 18 years and older, experiencing transitory neurologic events suggestive of seizures / epilepsy.

The most appropriate referrals are patients presenting with chronic uncontrolled epilepsy, newly diagnosed epilepsy and first time events suggesting seizures.

Please fax this form, completed by the Referring Physician to: 905-527-0059

Note: Inpatients and outpatients requiring **emergent neurological consultation** should be referred to the on-call Neurologist at Hamilton Health Sciences or their local emergency department.

Referral Source: ☐ Family Physician ☐ ER Physician ☐ Specialist _____

Physician (printed) Name _____ Phone Number _____

Patient's Age _____ years Date (yyyy/mm/dd) of last event: _____

Reason for Referral:

- ☐ First ever seizure / event
- ☐ Chronic uncontrolled
- ☐ Newly diagnosed
- ☐ Alternative opinion
- ☐ Transfer of care from Pediatrics
- ☐ Anti-Epileptic Drug Management / Optimization

Risk Factors:

- ☐ Mental Impairment
- ☐ ABI (Acquired Brain Injury)
- ☐ Tumor
- ☐ Family History
- ☐ Delayed Developmental Milestones
- ☐ Febrile Seizures
- ☐ None

Treatments initiated (if any):

- ☐ Phenytoin
- ☐ Oxcarbazepine
- ☐ Topiramate
- ☐ Vigabatrin
- ☐ Ativan
- ☐ Phenobarbital
- ☐ Valproic Acid
- ☐ Lamotrigine
- ☐ Clonazepam
- ☐ Levetiracetam
- ☐ Carbamazepine
- ☐ Divalproex
- ☐ Gabapentin
- ☐ Clobazam
- ☐ Other _____

Tests Ordered or Results Attached:

- ☐ CT
- ☐ EEG
- ☐ ECG
- ☐ EEG Monitoring
- ☐ MRI
- ☐ AE Drug Levels
- ☐ Holter Monitoring
- ☐ Other _____

Call back contact for clinic appointment booking: ☐ Patient **OR** ☐ Alternate Contact - _____

Phone Number (_____)_____ Relationship (if not patient) _____

_____ _____ _____

Referring Physician Printed Name | Physician's Signature and Designation | Date (yyyy/mm/dd)