Comprehensive Pediatric Epilepsy Program

Referral form for the Comprehensive Pediatric Epilepsy Clinic (CPEC)

For use of Pediatricians/Neurologists/Neurosurgeons only

Fax to 905- 521-5056

Patient Demographics

Date…….

Last Name……..First Name……

DOB……Sex M/F Weight…….Kg

HCN …….. Version code————

Address

Telephone#

Brief history

Criteria for referral. Check as applicable

1. Patients with established diagnosis of epilepsy who have recurrent seizures even after trying more than one appropriate medication at appropriate doses (with good drug compliance). They should have EEG, and if indicated, MRI brain completed or requested (MRI is not needed in benign focal epilepsy and primary generalised epilepsy syndromes).
2. Epilepsy with a defined focal brain lesion in MRI

Date of EEG Location

EEG report

Date of MRI Brain Location

MRI findings

If patient is awaiting MRI, please indicate when MRI

Current Medications with dose

1……..2…….

3……..4…….

Types of seizures with frequency and average duration

1.————————————-……(/day/week/month)……(sec/min)

2.————————————-……(/day/week/month)……(sec/min)

3.————————————-……(/day/week/month)……(sec/min)

Epilepsy Diagnosis ……..

Other diagnoses ……..

_____ _____

Name pediatrician **Signature**

OHIP#

Fax # Tel#

Kindly ensure

1. Criteria for referral are met
2. EEG and MRI reports (and other test reports) are attached (or indicate when MRI was requested)
3. Pediatric consultation note/follow up notes are attached

Please call 905 521 2100 ext 75613 if you wish to arrange a telephone consultation with an epilepsy neurologist at a mutually convenient time

For use of CPEP Personal

Date of triage Accepted/telephone consult/pending more information/declined

Reason for decline Alternate suggestion

Assigned to Dr……..