Adult Epilepsy Specialist Nursing Service

Referral Form v3 *(Post Migration to INTS s1 unit version Mar 24)*

*Please note the sections marked with a* \**are mandatory fields and must*

*be fully completed or the referral will be rejected.*

Date of referral: ………………………………………

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| \*PATIENT DETAILS  Patient Name: Patient D.O.B:Patient NHS Number: | Patient Address: Patient Post Code: Patient Tel. No: |
| \*REFERRED BY Name: Tel. No:Please tick below:- Consultant  GP  Specialist Nurse  Ward  Practice Nurse  Clinical Pharmacist  Other  please state:  Is patient aware of referral? Yes  No  Is patient already known to service? Yes  No  Unknown | |

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| **EXCLUSION CRITERIA *(Referrals received for patients with the following will be declined):-***   * **Patients under the age of 16.** * **Patients that do not reside within the Barnsley Borough or who are not registered to a Barnsley GP practice.** * **Patients that have not received an assessment with a Consultant Neurologist (only patients that have been issued a Consultant Neurologist management plan within the last five years can be accepted).** * **Alcohol withdrawal seizures (seizures within 48 hours of stopping drinking alcohol).** * **Seizures in relation to use of cocaine.** * **Non-epileptic attacks with no history of epilepsy and no ongoing treatment changes.** * **Medication supply issues.** |

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| **\*INCLUSION CRITERIA (*Please ensure all relevant information is ticked, failure to do so will result in the referral being rejected):-***   * **Patient is over the age of 16 and either resides in Barnsley or is registered with a Barnsley GP.** * **Patient has a diagnosis of epilepsy.** * **Patient has an existing epilepsy treatment / management plan (created within last 5 years by**   **a Consultant Neurologist).** |

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| **\*REASON FOR REFERRAL *(Please tick the primary reason for referral):-***  **Seizures  New On-Set Seizures  Medication Issues (side effects)  Pregnancy Related Matters**  **Education / Advice  Other (please specify)**  **Additional Information / Treatment Plan:** |

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| **PAST MEDICAL HISTORY / DISABILITIES** |

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| **MEDICATION** |