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** |