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| **Clinical Neurophysiology** **Referral for EEG** | **Department of Clinical Neurophysiology****University Hospital NHS Trust****Tremona Road****Southampton****Hampshire****SO16 6YD****Tel: 02381206785****Email: neurophysiologyadmin@uhs.nhs.uk** |

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous Surname |  | Title |  |
| Date of Birth |  | Sex | Male [ ]  Female [ ]  |
| AddressPost code |  | Home tel. no. |  |
| Work tel. no. |  |
| Mobile tel. no. |  |

**Referral Details:**

|  |  |  |
| --- | --- | --- |
| Referrer Name |  | Date of referral  |
| Referral Address |  |
| Patient Type | Outpatient [ ]   |  In Patient[ ]   | Ward:  |
| Tel. No.:  |
| Test required | Routine☐  | Sleep-deprived [ ]   | Ambulatory [ ]  | Melatonin Sleep [ ]  |
| For Melatonin Sleep EEG’s only  |  *Please note that this referral shall act as a one-off prescription and instruction for Neurophysiology to administer the following dose of liquid oral Melatonin to the patient as instructed by the prescribing referrer. Dose will be given on date of patient’s Neurophysiology appointment.* 2mg Melatonin (for under 5’s) [ ]  5mg Melatonin (for age 5’s and over) ☐Other [ ]  (please type dose and reason for alternative dose below) **Signature of referring prescriber:** |

**Clinical Information:**

|  |  |
| --- | --- |
| Length of time since symptoms began |  |
| Description of events (seizure semiology and frequency) |  |
| Family history / Past history of head injury? If yes please give details | Yes [ ]  No [ ]  |
| Relevant results from other tests MRI /CT scan / CSF studies etc |  |
| **Provisional Diagnosis:**  |
| Mobility Ambulant [ ]  Chair [ ]  Bed [ ]  |
| **Medication:**  | **Relevant PMH:**  |
| Incomplete request forms will be returned |

**HOSPITAL USE ONLY – CONSULTANT GRADING COMMENTS**