UHS logo 360 x 34

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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 |
| Address  Post code |  | Home tel. no. |  |
| Work tel. no. |  |
| Mobile tel. no. |  |

**Referral Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Named Consultant/GP |  | | | Date of referral | |
| GP Practice/ Department |  | | | | |
| Patient Type | Out Patient | In Patient | Ward | | |
| Test required | Routine☐ | Sleep-deprived | Ambulatory | | |  | | --- | | Melatonin Sleep | |
| For Melatonin Sleep EEG’s only | *Please note that this referral shall act as the prescription and instruction for Neurophysiology to dispense and administer the following dose of Melatonin to the patient as instructed by the referrer.*  2mg Melatonin (for under 5’s)  5mg Melatonin (for age 5’s and over) ☐Other  (please type dose and reason for alternative dose below) | | | | |

**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**