Children's Mercy HOSPITALS & CLINICS | Kansas City

Comprehensive Epilepsy Clinic Referral

Name: Date of Birth: / / Preferred name/s: Sex: ☐ Male ☐ Female Preferred language:	Address: Phone: Mobile: Email:
Alternative Contact:	
Period of referral: ☐ Immediate ☐ 1-3 months ☐ Next available	

Reason for patient referral and Epilepsy history:

Current Medication:

Drug name	Date started	Strength	Dose / frequency / special

Previous Anti-Epileptic Medications:

Drug name	Dose	Duration of use	Reason for stopping

Previous testing:

EEG date: EMU date: MRI date: Genetic date: Metabolic date:	EEG results: EMU results: MRI results: Genetic results: Metabolic results:

Other notes (eg current services):

☐ PT ☐ OT ☐ ST Vagus Nerve Stimulator ☐Yes ☐No Ketogenic diet ☐Yes ☐ No	Comments:

Please fax this referral to The Comprehensive Epilepsy Center 913-696-8580.

Please note that the absence of required information may lead to delays in processing the referral and subsequent appointment allocation.

Referring doctor:	Date: / /