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| **Newham Children’s Community Epilepsy Nurse Specialists** **Call 0203 738 7063** |
| **Details of Patient Referred**:**Child’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NHS No**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****D.O.B**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Parent/ Carer 1** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Parent/Carer 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Home Address***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Telephone number**:*1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***GP***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | ***Details of person making the referral:****Name of referrer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ward/Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date referral sent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of admission:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Is the CYP under safeguarding? Y/N**  *Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Supporting documents****: Please provide*Discharge summary:  Or comprehensive explanation of why referral is needed.**Parental /Carer discussed and permission given for referral:** Y / N(if this section is not completed the referral will be rejected and sent back) |
| **Essential Criteria**: all the below requirements must be met for referral to be accepted1. Diagnosis of Epilepsy  or strong suspicion of epilepsy diagnosis made by medical practitioner
2. Child must be aged 0-16
3. Child or young person must be a resident or attend a school within the London borough of Newham

New Diagnosis of epilepsy? **Y/N**Adherence to treatment issues or concerns? **Y/N** |
| **Medications:**Current Medications/treatment: **\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Rescue Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PTO Page 2  |
| ***Reason for referral/medical history/other issues:*** |
|  |
| *For EPILEPSY USE ONLY:**Date referral received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Triaged by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Contact made: Y/N Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Planned Visit\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Priority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Named Nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admin staff admitting patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**RIO Diary entry Case load  Personal diary*  |

Please return both pages of this form to:

Email: elt-tr.CCNSNewham@nhs.net

**Criteria**

* Eithera definitive Epilepsy diagnosis or strong suspicion of epilepsy diagnosis made by medical practitioner
* Aged 0-16
* Child or young person must be a resident or attend a school within the London borough of Newham