

Seizure Monitoring Referral Form

Date:

Physician:

Patient Name:

_____ Inpatient _____ Outpatient (4 hour)

Age:

Age at seizure onset:

Suspected seizure type:

Seizure frequency:

Current medications:

Medications tried in the past:

Rationale for monitoring:

Please fax this form with an H&P and patient demographics to
502-562-3993 and we will schedule the patient ASAP

Comprehensive Epilepsy Center University Hospital
530 S. Jackson St. Louisville, KY 40202
502-562-4169