Hartford HealthCare

Ayer Neuroscience Institute

Epilepsy Clinic Referral Form

Medical Office Building, Suite 815
85 Seymour St, Hartford CT 06102
Phone: 860.972.3621
Fax: 860.545.5003

Patient Name: ____. Date of Birth: ____

Phone number: ____. Alternative Phone Number: __________________________

Please select one type of referral (in bold)

☐ **Standard Evaluation for Seizures or Epilepsy**: (target time 1-2 months)

1. Is this an Urgent referral? Yes ☐ No ☐
2. Is the patient having more than 2 seizures per month: Yes ☐ No ☐ Unknown ☐
3. Has the patient tried more than 2 seizure medications? Yes ☐ No ☐ Unknown ☐
4. Has the patient had an EEG? Yes ☐ No ☐ Unknown ☐
   a) If Yes, was it an inpatient, multiple day duration EEG (EMU)? Yes ☐ No ☐ Unknown ☐
   b) Where was the prior EEG performed? ____________________________________
5. Has the patient had a brain MRI or Head CT scan? Yes ☐ No ☐ Unknown ☐
   a) If Yes, was the MRI/CT scan abnormal? Yes ☐ No ☐ Unknown ☐
   b) Where was the prior MRI/CT performed? ____________________________________

☐ **First Seizure Clinic Referral:** (target time 1-2 weeks)

1. Has the patient had a recent first seizure event? Yes ☐ No ☐ *(If No, select "Standard Evaluation for Seizures")*
2. Has the patient been seen by a neurologist within the past year? Yes ☐ No ☐ *(If Yes, consider having them see that neurologist or referring them for a "Standard Evaluation for Seizures")*

☐ **Post Hospital Referral:** (target time 2-4 weeks)

1. Was the patient seen by Neurology in the inpatient setting? Yes ☐ No ☐
2. Has the patient already seen a neurologist in the outpatient setting? Yes ☐ No ☐
   a) If Yes, what is their name? ____________________________________

Referring Provider:

Name (please print): ________________________________ Signature: ____

Phone: ____. Fax: ____