Comprehensive Epilepsy Center
Division of Pediatric Neurology Consult Appointment Request
University of Texas Southwestern Medical Center at Dallas • Children's Medical Center of Dallas
Office: 214.456.2768 **Fax: 214.456.2554**

*** IMPORTANT NOTICE ***

Only ***COMPLETED*** referral requests are reviewed.

Please fax 1) this completed form, 2) copies of **ALL** medical records requested, and 3) **ALL** test results requested to 214.456.2554

*** Please note: Patients turning 18 within six months will need to be referred to an adult neurologist.**

1 Indicate the reason for the Neurology appointment request:

☐Epilepsy/Seizure Disorders ☐New Onset Seizure ☐2nd opinion for Epilepsy

What is the primary ***Neurological*** Diagnosis? (reason child needs to be seen) Click here to enter text.

2 Provide patient information:

Child's Name: Last First Middle DOB: Click here to enter a date. Age: ☒M ☐F

Referring MD: MD Phone: MD Fax:

Family contact #s: Home: Work: Other:

Parent Name(s) Insurance:

Parent Address: City/St: Zip Code:

Current medications:

Other medical problems/diagnosis:

Other Neurologist/Specialist who has seen this child (name and specialty):

3 **We require the following for all *Epilepsy/Seizure Disorder* and *New Onset referrals*:**

Date of last EEG*: Click here to enter a date. Location:

* **IMPORTANT** – Fax EEG results to 214.456.2544. If an EEG has NOT been done in the last six months, please schedule an EEG, let us know the date, and fax the results when received. (To schedule an EEG at Children's Medical Center at Dallas, call 214.456.2740)

Number of seizures: Frequency of seizures:

List of current seizure medications:

4 Notes for physician/additional information: Click here to enter text.

OFFICE USE ONLY

Reviewed by:	Date:	*Office use only:*
☐Schedule Appointment: ☐Next available with: ☐Overbook (date/time): ☐Other: ☐Appointment NOT approved/required: ☐No appointment necessary: ☐Unable to evaluate at this time ☒Alternate referral to: Click here to enter text.		

CHILDREN'S MEDICAL CENTER

PHYO
CMC 38380-007NS Rev. 7/2012

Neurophysiology Laboratory Requisition
Electroencephalogram (EEG) and Evoked Potential (VEP, SSEP, BAEP)

MED REC NO. _____ ACCT NO. _____
PATIENT _____
DATE _____ LOCATION _____
DOB _____

	Name	Phone #	Fax #
Referring provider information			
Primary care physician			

Type of study requested:	☐ Awake and asleep Electroencephalogram (EEG) (with sleep deprivation) ☐ Awake Electroencephalogram (EEG) ☐ _____ Hour outpatient EEG monitoring with Video ☐ 24 hour outpatient ambulatory EEG monitoring without video ☐ 48 hour outpatient ambulatory EEG monitoring without video ☐ Brainstem Auditory Evoked Potential (BAEP) ☐ Somatosensory Evoked Potential (SSEP) ☐ Visual Evoked Potential (VEP)
For all evoked potential orders:	Please note known sensory or motor deficits: _____
What do you want to learn from this study?	Seizures / Possible seizures ☐ *Febrile* ☐ *Absence* ☐ *Generalized* ☐ *Partial* ☐ *Infantile spasms* ☐ *Other (specify):* ☐ Other _____ Compare w / prior CMC EEG: (date) _____ Possible focal brain disorder: (specify) _____ Screen for any brain disorder: (specify) _____ **For all studies:** Please specify the question you would like answered:
Diagnoses: (Please give diagnosis code(s) _____ _____	Medications patient is taking: _____ _____ _____

I have discussed the indications for the procedure with the patient's parents or legal guardian.

Referring Provider signature and credentials: *(required)* **(Circle one): MD DO APN PA AA CRNS RN**	**Date:** **Time:**
Print Provider name:	**Office contact person:**

CMCD Neurophysiology Fax #- 214-456-7305