

For Office Use Only: Date Received: _____ Date Scheduled: _____

 Epileptologist: _____ EEG: _____

**LSU Epilepsy Center of Excellence
Patient Referral Form
Fax to Angela at 504-412-1518**

Name

Social Security Number

DOB / SEX

Referring Physician

Address

Person Calling/Faxing and Office Number

City/State/Zip

PCP/Phone Number

Home Phone Number

Primary Insurance/Phone

Cell Phone/Beeper Number

Group# / Member #

Work Name and Number

Policy Holder/DOB/Relation to Patient

Alternate Contact/Relation to Patient

Secondary Insurance/Phone

Alternate Contact Phone Number

Policy Holder/DOB/Relation to Patient

Reason For Referral:

- Poor Seizure Control
- Surgical Evaluation
- Monitoring
- Non-epileptic
- VNS
- Second Opinion

Record Checklist:

- MRI/PET/SPECT
- EEG
- Last visit
- Current Meds
- Labs (recent AED levels)
- Operative Report
- Neuropsychological Report

Notes for Epileptologist:

