Office use only	Date received	Date scheduled

CHILDREN'S HOSPITAL EPILEPSY CENTER
NEW PATIENT REFERRAL FORM

Please complete the information below and return by fax.
The Medicaid Community Care or private insurance authorization MUST accompany this form.
We will contact the referring physician's office within 2-3 working days of referral receipt.

Patients Name _____ M/F DOB _____

Parents Name _____

Address _____
(include city, state, zip code)
_____

Home Phone _____ Cell Phone _____
(include area code)

Insurance _____ Policy # _____

Please include the following information:

1) **Reason for referral**:

□ Poor seizure control □ 2nd opinion □ Surgical evaluation
□ VNS □ Monitoring □ Non-epileptic

2) **Referring physician's notes pertaining to epilepsy center referral**

3) **Record checklist**: (Bring digital or hard copies if available)

□ EEG/Video EEG □ MRI/SPECT/PET □ Current medications □ Labs (AED levels)
□ Operative report □ Neuropsychological report □ Notes from previous epileptologist/ neurologist

Referring Physician Name _____

Referring Physician Address _____
(include city, state, zip code)
_____

Referring Physician Phone (_____)_____Fax (_____)_____

Children's Hospital Epilepsy Center
200 Henry Clay Avenue, suite 3312
New Orleans, LA 70118
Phone: (504) 896-9859 Fax: (504) 896-9547