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

Epileptologist: _____ EEG: _____

LSU Epilepsy Center of Excellence
Patient Referral Form
Fax to Barbara 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:

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