**Community Children’s East Kent Epilepsy Service – referral form**

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| Name: | Date of Birth: | M □ F □ |
| Child’s Address:  Postcode: | School / Nursery / Health Visitor: | |
| Telephone : | Language: | |
| Interpreter Required? Y□ N □ | |
| NHS Number: | Religion: | |
| Family known to Social Services? N □ Y □ Social Worker Name:  Is Child Subject to:  ● Child Safeguarding Plan? □ Contact Details:  ● Child In Need Plan? □  ● Is Patient a Looked after Child? Y □ N □  ***\*\*Please also document any concerns/risks which may impact on staff safety during home visits \*\**** | | |
| Ethnicity  Please Tick / Specify:   |  |  |  |  | | --- | --- | --- | --- | | **Code** | **Ethnicity** | **Code** | **Ethnicity** | | A | White British | K | Bangladeshi | | B | White Irish | L | Asian Other Background | | C | White Other background | M | Black Caribbean | | D | White and Black Caribbean | N | Black/African | | E | White and Black African | P | Black Other | | F | White and Asian | R | Chinese | | G | Mixed Other Background | S | Any Other Ethnic Group | | H | Indian | Z | Asked but declined | | J | Pakistani | | | |
| **Who has Parental Responsibility?** | | |
| **Parent / Guardian’s Name:** | **Relationship:** | |
| **Other Health Professionals Involved:**  **GP Name:**  **GP /Contact Details:** | **Consultant / Contact [TERTIARY]:**  **Consultant Name / Contact [LOCAL]:** | |

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| **Diagnosis: (*Please incl. Known Allergies)*** |
| **Reason for Referral:** |
| **Medication:** |

**Doctors only - If training or a care plan is required for emergency medications please complete the following information:**

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| **Medication** | Midazolam □  Paraldehyde □  Diazepam □ |
| **Dose** |  |
| **Description of seizures requiring emergency treatment** |  |
| **When should emergency medication be given (after how many minutes or how many seizures)** |  |
| **Can the dose be repeated** | Yes □ No □  If yes how many minutes after the first dose? |
| **When should an ambulance be called?** | On onset of seizure □  If midazolam is given □  If the seizure has not stopped within 10 minutes of the first dose □  Other – please specify |

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| **Child /Family Aware of Referral: Y** □ **N** □ |
| **Name and Designation of Referrer:**  **Contact Details:**  **Date:** |