**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 |

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| **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:**

|  |  |
| --- | --- |
| **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:** |