Saskatchewan Health Authority

Rapid Access Single Seizure Clinic Referral Form

INITIAL APPLICABLE BOXES

Patient Name:

Date of Birth:

HSN:

Address:

Phone:

Alternate Phone:

Send completed referral form to:	Saskatchewan Epilepsy Program Royal University Hospital, Saskatoon, SK Phone: 306-844-1134 Fax: 306-655-7489

Prognostic Index for Single Seizure (Triage Scoring)		
Seizure Occurrence (any type)	1 prior to presentation	1
	2+ prior to presentation	2
Seizure Type (circle)	Focal/Tonic-Clonic/Absence	
Timing	From sleep	1
Epilepsy Risk Factors:	Childhood seizures, including febrile seizures	1
	History of CNS infection	1
	History of CNS insult (i.e. stroke or traumatic brain injury)	1
	First degree relative with epilepsy	1
	History of developmental delay or premature birth (<37 weeks)	1
	History of abnormal EEG (showing tendency to seizure)	2
	Total Score	

History and Description of Symptoms (Initial all that apply)

- ☐ Tongue trauma
- ☐ Incontinence
- ☐ Post-ictal drowsiness
- ☐ Post-ictal confusion
- ☐ Pallor
- ☐ Diaphoresis
- ☐ Tunnel vision
- ☐ Lightheaded
- ☐ Cardiac history: arrythmia, structural heart diagnosis, etc.
- ☐ Substance use (including alcohol, alcohol withdrawal, stimulants)

Details (must be included): _____

_____

_____

_____

_____

Investigations – Completed/Booked
Attach results, if available

Test	Date	Results	
		Normal	Abnormal
CT*		☐	☐
MRI		☐	☐
EEG		☐	☐
Lab work		☐	☐
CK/VBG lactate/(+/- prolactin)**		☐	☐
ECG*		☐	☐

*must be done prior to clinical assessment
** do for all patients presenting immediately post seizure;
Prolactin level may be done if drawn within 20 minutes of seizure.

Treatment Initiated: ☐ No
☐ Yes - **treatment and dose:**

_____

SGI Notification **MANDATORY with referral**
☐ No ☐ Yes – date completed _____

Confirmed syncope does not require EEG or referral for assessment. If suspicion for seizure with syncopal event remains high, please refer.

If patient has a fever, focal findings or incomplete recovery from the event, please call the Neurologist on call prior to the referral.

Referring Doctor: _____ **Signature:** _____