

New Patient Checklist - Epilepsy 12 audit

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| **First name** |
| **Surname** |
| **Gender Male Female** |
| **DOB** |
| **NHS Number** |
| **Home Postcode** |
| **GP Practice Postcode** |
| **Date Referred for first EEG** |
| **Contact details provided** YES / NO **details provided** Landline / Email / Mobile |
| First aid information provided |
| Prolonged seizure care plan required? |
| Were any of the epileptic seizures convulsive ? |
| Has the child experienced GTC longer than 5 minutes ? |
| Has the child experienced focal seizures lasting longer than 5 minutes ? |
| Is there a family history of epilepsy ? |
| Is there a history of neonatal seizures ? |
| Is there a history of febrile seizures ? |
| Has the child had any acute symptomatic seizures ? |
| How was child referred to clinic? |
| Date of initial referral : |
| Investigations : |
| EEG:  ECG:  CT Head:  MRI:  Other : |
| Risks and lifestyle : |
| 1)General participation and risk |
| 2)Water safety |
| 3)SUDEP |
| 4)Road safety |
| 5)Safety at heights |
| 6)Sleep monitoring |
| 7)Photo sensitivity |
| Treatment information : |
| 1)Goals |
| 2)Drug information leaflets |
| 3)Sodium valproate risks and benefits |
| 4)VNS option |
| 5)Ketogenic diet |
| 6)other |
| About My Epilepsy: |
| 1)Seizure diary |
| 2)Seizure types |
| 3)Syndrome type |
| 4)Prognosis |
| 5)Co-morbidities |
| 6)National support groups |
| 7)Other |
| Transition: |
| 1)Driving |
| 2)Contraception / pregnancy |
| 3)Adherence |
| 4)Sleep hygiene |
| 5)Recreational drugs / alcohol |
| 6)Career |
| 7)Bus pass |
| 8)Seen on own |
| 9)Self management |
| 10)Goal setting |
| Education : |
| 1)Care plan required? |
| 2)Does the child have an EHCP? |
| 3)Consent to share information with school ? |
| 4)Teacher generic epilepsy awareness |
| 5)exam provision |
| 6)School rescue medication plan |
| 7)School rescue medication training |

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent /carer consent to Epilepsy 12 ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_