# Description: GOSH FT_COL.jpg

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**CESS referral Proforma:**

[ ]  I would like to refer the patient below for evaluation for epilepsy surgery:

[ ]  I would like to refer the patient below for discussion in the CESS MDT meeting as VNS treatment should be considered as next treatment option (**please note this** **option can only be accepted if referral is made by the regional paediatric neurology service**)

|  |  |
| --- | --- |
| **Name** |  |
| **Date of birth** |  |
| **NHS number** |  |
| **Address** |  |
| **GP** |  |
| **Referring Consultant and Hospital:** |  |
| **Lead Regional Paediatric Neurologist and regional neurosciences centre (if not referrer)** |  |
| **Working diagnosis (seizure and epilepsy syndrome)** |  |
| **Birth complications** | [ ]  No[ ]  Yes details: |
| **Genetic diagnosis or chromosomal abnormality?** | [ ]  No[ ]  Yes details: |
| **Structural abnormality on MRI**  | [ ]  No[ ]  Yes details: |
| **Details of seizures** ***(we cannot accept referrals without completion of this section in full)*** |
| **Age of onset** |  |
| **Is there a history of spasms?** | [ ]  Yes [ ]  NoIf yes details: |
| **Seizure type at onset, and subsequent if different from current** |  |
| **Current Seizures** | **Frequency** |  |
| **Type 1**  | [ ]  **Daily**[ ]  **Weekly**[ ]  **Monthly** | **Description of seizure (please include details of any aura, clinical features observed and triggers)** |
| **Type 2**  | [ ]  **Daily**[ ]  **Weekly**[ ]  **Monthly** |  |
| **Type 3** | [ ]  **Daily**[ ]  **Weekly**[ ]  **Monthly** |  |
| **Is there a history of status epilepticus (please give details)** | [ ]  Yes [ ]  NoIf yes details: |  |
| **Have seizures been captured on video EEG telemetry?** | [ ]  No [ ]  ***If Yes, please state clearly where this was performed ………………………..***  |
| **Current medication and dose** |  |
| **Previous medications** |   |
| **Neurodevelopment** |
| **Developmental milestones:** **Motor:** [ ]  normal [ ]  delayed[ ]  plateauing [ ]  regression, age : **Language:**[ ]  normal [ ]  delayed[ ]  plateauing [ ]  Language regression, age : …….[ ]  Changes in speech, age ……..**Cognition:** [ ]  Typical [ ]  Global developmental impairment[ ]  Diagnosis of intellectual disability/ learning difficulties, Severity (if known)\_............\_\_\_\_ | **Current skills:** **Language :** [ ]  typical for age[ ]  delayed/impaired[ ]  nonverbal *Expressive skills*: [ ]  single word[ ]  phrases[ ]  sentences*Receptive skills:* [ ]  Words[ ]  1 step instruction[ ]  2 step + instructions Motor: [ ]  Hemiplegia (right/left)[ ]  Bilateral movement disorder (upper limb/lower limb/four limb)[ ]  GMFCS/equivalent: |
| **Schooling:** [ ]  Preschool[ ]  Mainstream [ ]  Mainstream with EHCP[ ]  Special school [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Academic progress:** [ ]  As expected [ ]  Below level expected [ ]  Plateauing[ ]  Regression, age: [ ]  Specific difficulties[ ]  Not known Comments:  |
| **Developmental comorbidities:** [ ]  Autism[ ]  Attention Deficit (Hyperactivity) Disorder[ ]  Behaviour that challenges [ ]  Mood disorders[ ]  Anxiety [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **If over 6, estimate of overall level of functional skills:** [ ]  As expected for age[ ]  Needing some more support than expected for age e.g. prompting[ ]  Skills at a preschool level- e.g. needing adult help for self-care[ ]  Fully dependent on adults [ ]  Unknown |
| **Has the child previously had a formal neuropsychology or developmental assessment ?** | [ ]  No [ ]  Yes (please send any reports available) |
| **Safeguarding concerns:**  | [ ]  Yes [ ]  No If Yes, details: |
| **EEG** | Please confirm [ ]  All relevant EEG reports enclosed (mandatory information - we cannot process referral without this)[ ]  Dates for EEG reports enclosed:…………………………………… |
| **Are any home videos of seizures available ?** | [ ]  Yes - our CESS administrator can register parents / carers for our secure digital platform vCreate to upload these home videos[ ]  No  |
| **MRI Images** **(other neuroimaging)**  | Please confirm [ ]  Reports attached (please state Hospital where MRI (s) were performed and date(s) [ ]  **Images have been send by IEP; Date send:………..****(mandatory-we cannot process referral without neuroimages)** |
| **Genetic investigation performed**  | [ ]  No[ ]  Yes: all reports attachedwhich tests:  [ ]  Results pending:which tests:  |
| **Other investigations:****Please tick as appropriate** [ ]  **Metabolic** [ ]  **Autoimmune**  | Please summarise relevant results: |
| **Any additional relevant information:**  |  |