# 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  No  If 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  No  If 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 attached which tests:    Results pending: which tests: |
| **Other investigations:**  **Please tick as appropriate**  **Metabolic**  **Autoimmune** | | Please summarise relevant results: |
| **Any additional relevant information:** | |  |