Print Reset Form Fields

MUSC Health
NEUROLOGY SERVICES

New Onset Seizure Clinic Referral

Patient Name:_____

Patient DOB:_____/_____/_____ Patient Home Phone:_____

Patient Other Phone:_____

Patient Insurance: _____
Please attach a copy of the front and back of the insurance card

Previous Tests:
Brain MRI (date/loc)_____EEG (date/loc)_____

Head CT scan (date/ loc)_____Other (date/loc) _____

Referring MD:_____ MD Office Phone:_____
Referral for suspected seizure.

Referral Order (select one):

☐ Please perform a consultation for etiology of recent seizures/ episodes, **including an EEG**.

☐ Please perform a consultation for etiology of recent seizures/ episodes. An EEG was **recently done** at MUSC already.

Future Planning (select one):

☐ Referral for Diagnosis and Continued Management

☐ Referral to MUSC for Diagnosis only, with continued management by the referring MD

_____ _____
Referring MD Signature Date

Please fax completed form and records to 843-876-0319