

Alfred Sandringham Caulfield

REFERRAL FOR VEM ADMISSION - Video EEG Monitoring

Last name*		First name/s*		Date of birth*	
*mandatory fields					
<ul style="list-style-type: none"> Attach all relevant histopathology reports and investigations Your patient will be contacted with appointment details 					
Epilepsy Unit T 03 9076 2460 F 03 9076 7864 E epilepsy@alfred.org.au					
Address The Alfred, 55 Commercial Road, Melbourne, VIC, 3004					
Patient Portal					
The Patient Portal enables patients to easily access their Alfred Health appointment and health information online. Patients are encouraged to register, once they have received a Medical Record Number.					
Patient details					
Sex		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		Telephone	
Address				Email	
Medicare No		Reference No		Expiry	
NDIS No		<input type="checkbox"/> Bulk Bill <input type="checkbox"/> Private <input type="checkbox"/> Pensioner <input type="checkbox"/> TAC <input type="checkbox"/> WorkCover <input type="checkbox"/> DVA <input type="checkbox"/> Other			
Interpreter		<input type="checkbox"/> Yes <input type="checkbox"/> No		Language	
Indigenous status		<input type="checkbox"/> Not Aboriginal or Torres Strait Islander <input type="checkbox"/> Torres Strait Islander not Aboriginal <input type="checkbox"/> Aboriginal not Torres Strait Islander		<input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Not specified	
Cultural considerations / support needs / disabilities					
Contact person name		Relationship		Telephone	
Brief clinical summary – attach detailed clinical notes					
Medication list – or attach					
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No		List			
Referral					
Recommended VEM admission type		<input type="checkbox"/> Maxi (complete epilepsy admission) <input type="checkbox"/> Mini (non-complex epilepsy admission) <input type="checkbox"/> Either Maxi or Mini			
Urgency		<input type="checkbox"/> Urgent (within 4 weeks) <input type="checkbox"/> Within 3 months <input type="checkbox"/> Next available			
Comments					
VEM admission required data					
Indication		<input type="checkbox"/> Surgical Evaluation <input type="checkbox"/> Assessment without medication change <input type="checkbox"/> Suspected functional seizures <input type="checkbox"/> Diagnostic characterisation <input type="checkbox"/> Non-surgical drug-resistant epilepsy evaluation <input type="checkbox"/> Other			
Comments					



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Last name*		First name/s*		Date of birth*	
SPECT					
SPECT priority		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Not for SPECT			
Complex care needs		<input type="checkbox"/> Behavioural issues <input type="checkbox"/> High nursing care needs <input type="checkbox"/> Post-ictal aggression <input type="checkbox"/> Addiction <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Carers <input type="checkbox"/> Paediatric (<16 years) <input type="checkbox"/> Other			
Comments					
Cardio respiratory monitoring		<input type="checkbox"/> High <input type="checkbox"/> Low			
Subtemporal electrodes		Recommended for surgical admissions in patients with presumed TLE		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other additional electrode		Consider for selected very good surgical candidates and/or repeat VEM for surgical workup		<input type="checkbox"/> Yes details <input type="checkbox"/> No	
Specific electrode instructions					
Assessments completed – attach copies of externally completed reports					
MRI Brain		<input type="checkbox"/> Yes, at The Alfred <input type="checkbox"/> Yes, where _____		<input type="checkbox"/> None prior <input type="checkbox"/> Requested, where _____	
FDG-PET		<input type="checkbox"/> Yes, at The Alfred <input type="checkbox"/> Yes, where _____		<input type="checkbox"/> None prior <input type="checkbox"/> Requested, where _____	
Video-EEG		<input type="checkbox"/> Yes, where _____ <input type="checkbox"/> No			
Comments					
Investigations required during VEM admission		<input type="checkbox"/> MRI <input type="checkbox"/> PET <input type="checkbox"/> Interictal SPECT <input type="checkbox"/> fMRI-language <input type="checkbox"/> Neuropsychology <input type="checkbox"/> Other			
Comments					
Neuropsychiatry inpatient assessment priority		<input type="checkbox"/> High (<i>functional seizures, suspected or diagnosed. Poorly controlled comorbid psychiatry condition, suspected or diagnosed. Significant cognitive impairment</i>) <input type="checkbox"/> Low (<i>repeat VEM, previously assessed. Non complex adjustment to epilepsy diagnosis. All other patients</i>) Note: Not all low priority patients will receive this assessment			
Inpatient management					
ASM (anti seizure medication) management		<input type="checkbox"/> Referrer instructions <input type="checkbox"/> Determined by ward consultant <input type="checkbox"/> No medication change			
Sleep deprivation		<input type="checkbox"/> Referrer instructions <input type="checkbox"/> Determined by ward consultant <input type="checkbox"/> No sleep deprivation			
Sleep reversal		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Recommended if for SPECT / predominant nocturnal seizures.</i> Reversal instructions to begin the weekend before admission			
Referring Neurologist details (Neurologist referrals only accepted)				Referral date	
Referrers name		Provider number			
Telephone		Email		Fax	
Address					
Copies to					

 Return referral to epilepsy@alfred.org.au

EMR: Admission / Admission Request