FIRST SEIZURE CLINIC CLERKING PROFORMA

Name:		Surname:			
DOB:		Hospital #:			
Date:		Handedness:		Weight:	
Referrd From:		Referral Date:			

BACKGROUND

Birth History:	
Past Medical History:	
Hx of Neonatal or Febrile Sz?:	
Drug History, Allergies & Imms:	
Family History & Hx of Epilepsy:	
Developmental History:	
School/Behaviour/Emotional Hx:	
Sleep:	
Diet & Growth:	

SEIZURE HISTORY

Date of first seizure:		Frequency of seizure:			Last seizure:	
Description of seizure:						
Was it convulsive or prolonged?						
Classification of seizure:						

INVESTIGATIONS

1st EEG Date & Result:		CT/MRI Date & Result:	
1st ECG/QTc Date&Result:		Baseline Bloods:	

EXAMINATION

General		Neuro	

SAFETY ADVICE

Participation		Heights		Water		Heat	
Traffic		SUDEP		Sleep		Flashing Light	

EMERGENCY ADVICE

First aid plan:	
Prolonged seizure plan?	
Commence rescue meds?	

PLAN

	Commence AED + s/eadv?	
	For Epilepsy Surgery?	
	Contact details given?	
	Transition?	
	School IHP?	
	Valproate register?	