EPILEPSY MONITORING UNIT (EMU) REFERRAL FORM FOR NEUROLOGISTS EXTERNAL TO CHEO

Thank you for your referral. Please fax completed form to (613) 738-4879 or mail to:
Children's Hospital of Eastern Ontario, Clinic CA, 401 Smyth Road, Ottawa, ON K1H8L1

- EMU admissions are usually 3 days though in some instances, such as surgical evaluation, 4 days may be required
  The CHEO EMU team will:
  - ✓ Triage all referrals for appropriateness and acuity. Referring provider will be informed of the triage result **NOTE incomplete referrals will be returned**
  - ✓ Contact the patient or family directly with the EMU date and admission information.
  - ✓ Send written EMU results to the referring physician. If urgent, we will page the referring physician. In general, we do not give families EMU results on the day of discharge.

- The referring physician:
  - ✓ Should tell patients and families about the referral, and give some basic information about an EMU admission. Please refer families to the CHEO website for what they should expect when visiting the EMU: http://www.cheo.on.ca/en/EMU
    - ✓ Must arrange any tests needed before or after the EMU stay.
    - ✓ Must give weaning instructions (if applicable) directly to the patient. Please record weaning details on the referral form, including the dates when weaning will begin.

A. Inclusion criteria :

We accept referrals for patients living in the Champlain, Central East, North East and Southeast LHINs**.** All patients must already have had a neurology consultation (including neurologic examination). Events should be occurring more frequently than once/month for a reasonable chance to capture them. If this is not the case, please note on the referral why you feel EMU is necessary. Otherwise, they will either be declined or be placed at the end of the waitlist.

With this referral, please include:

- ☐ Initial neurologic consultation
- ☐ Most recent neurology clinic note
- ☐ All previous EEG reports

B. Patient information :

Surname: _____ Given Name: _____

Date of Birth (dd/mm/yyyy):_____ Health Card Number: _____

Home address: _____ City: _____ Postal Code: _____

Home phone: _____ Alternate phone: _____

Name of Parent(s)/Guardian(s): _____

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C. Referring physician :

Name: _____ Phone: _____ Fax: _____

Address: _____

D. Clinical history :

_____

_____

_____

_____

E. Medications :

Drug	Dosage/Frequency	Are Medications being weaned? Y/N

If applicable, include medication weaning schedule provided to the patient, including weaning start date.

Drug	Weaning Instructions

F. Seizure types :

(Please include all epileptic seizures and any suspected non-epileptic events):

EVENT type	Clinical Description	Frequency

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G. Behavioral/psychosocial/developmental considerations :

_____

_____

_____

H. Goals of video EEG monitoring : Check all that apply

- ☐ Pre-surgical evaluation (NOTE: events must be happening >2/week or medication weaning Instructions must be provided to the family-)
- ☐ Medical management
- ☐ Diagnosis
- ☐ Other (-Please describe):

_____

_____

_____

I. Will sedation be needed for electrode application? Check **one**

- ☐ Yes
- ☐ No
- ☐ Unsure

J. Are parents aware of the goals, location and duration of the EMU admission?

- ☐ Yes
- ☐ No

K. Additional notes for us to consider :

_____

_____

_____

_____

_____

Date: _____ **Signature: _____**

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