SOUTH EAST WALES CLINICAL NEUROPHYSIOLOGY SERVICE

Sedated EEG with melatonin

SURNAME	**FIRST NAME**	**CONSULTANT (Full surname)** **REFERRING HOSPITAL**		
ADDRESS **POSTCODE**		**DATE OF BIRTH**	**HOSPITAL NUMBER**	**PARENT TELEPHONE NUMBER**
Provisional diagnosis, brief history including any special needs and reason for sedated EEG with melatonin: Previous EEG result Current medication: Weight of child…….				
The test involves skin abrasion. Is there known or suspected risk of hepatitis B/C, HIV, MRSA, JCD? If yes, please specify…… This information will be treated in strict confidence and will only be used to protect staff who may be at risk				
***DOCTOR'S SIGNATURE** **NAME** **DATE**				

Prescription for Melatonin

Date of test	Medicine	Mark 1 below for each dose to be supplied	Oral dose	Quantity issued by pharmacy	Frequency	Date given	Time given	Given by
	Melatonin Melatonin		5 mg 5 mg		Stat 20 min later if required			
Pharmacist clinical check:			To be seen again by pharmacist: Yes/No (circle)			Dispensed by:		Checked by:

*** DOCTOR'S SIGNATURE_____NAME_____ DATE_____**
Contact/Bleep no:

PLEASE NOTE THAT A DOCTOR'S SIGNATURE IS REQUIRED AT BOTH ASTERISKS *

INCOMPLETE FORMS WILL BE RETURNED

Additional information overleaf

Notes for referrer/prescriber

1. The weight of child must be specified as this is essential for pharmacy to dispense the Melatonin

2. When the date of the test is known, this will be written on the left of the prescription chart by neurophysiology staff

3. Please state dose to be supplied ie 1 X 5mg or 1 x 5mg x 2

4. The original form will be filed in the patient's casenotes by Paediatric Short Stay Unit staff. A copy will be retained by the Neurophysiology Department.