GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

SOUTH EAST WALES NEUROPHYSIOLOGY SERVICE

VIDEO EEG MONITORING (VEM) REFERRAL FORM

First Name	Surname	Date of Birth	Consultant

Hospital Number:

Address

Tel No: Home

Work

Mobile

Previous EEG(s) *Most Recent First*

Date	Where	Result

FOR OFFICE USE

Reason for VEM

Provisional Diagnosis

Current Medication

Seizure Types	Frequency
1.	
2.	
3.	
4.	

Has the patient suffered any of the following?
(Elaborate if necessary)

1. Head Injury

2. Intracranial infection/Surgery

3. Febrile Seizure

4. Photosensitivity

5. Myoclonic Jerks

6. Learning Disability

Relevant Past History

Relevant Family History

Smoker: Yes / No

Alcohol Intake:

Need ambulance transport to attend: Yes / No

Neuroimaging results

1. Are staff considered at risk from patient?

2. Any known or suspected risk of transmissible infection?

3. Any history of violent behaviour before during or after seizure?

4. Any risk of injury to patient during a seizure

Signed: -- **Date**:--------------------------------------

A copy of all relevant correspondence would be most welcome