Neurophysiology Referral Form

Cleveland Clinic
London

Please complete all known information on this form and email to CCLREFERRALS@ccf.org or fax to +44 (0)20 7890 4466

Patient Details	Referrers Details
Patient Name:	Full name:
Date of birth (DD/MM/YYYY):	Signature:
Gender:	Date:
Street address:	Designation:
	Contact No.:
Postcode:	Email:
Telephone / Mobile:	
Email:	
First language:	
Interpreter required: ☐ Yes ☐ No	
Infection control precautions:	

Reason for Referral and Clinical History

Medical History:

Current Medication/s: ☐ Anti-epileptics ☐ Anti-coagulation ☐ Pyridostigmine (Mestinon) ☐ Neostigmine ☐ Other (comment below)

Further comments (Medications, Allergies):

Electroencephalography (EEG)

☐ **EEG**

☐ **Home-Video Telemetry (HVT)**

HVT involves EEG, video and audio recording of the patient and their surrounding environment throughout the procedure. They will be required to be at home for the duration of this investigation.

☐ 24 hour ☐ 48 hour ☐ 72 hour

Nerve Conduction Studies (Ncs) / Electromyography (EMG)

Guided Botox injection required? ■ Yes ☐ No

EMG with Small Fibre Studies required? ☐ Yes ■ No

Single Fibre EMG? ☐ Yes ■ No

Specific regions to be tested:

Evoked Potential Studies

☐ Visual Evoked Potentials (VEP)

☐ Somatosensory Evoked Potentials (SSEP): Upper OR Lower Limbs

☐ Somatosensory Evoked Potentials (SSEP): Upper AND Lower Limbs

☐ Brainstem Auditory Evoked Potentials (BAEP)