OTTAWA EPILEPSY PROGRAM

Women With Epilepsy Clinic

Referral Form

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Current antiseizure medication(s): _____

❖ Please select one type of referral:

◯ **Management of antiseizure medication(s) and pregnancy:**

1. Is it a referral for a patient who is pregnant? Yes ☐ No ☐

   If yes,

   a) What is the gravity and parity of pregnancy? G ☐ P ☐ A ☐ L ☐

   b) When was the first day of her last menstrual period (LMP)? _____

   c) Is she seizure free? Yes ☐ No ☐

   d) When was the last seizure? _____

   e) Is the patient following with an OB? Yes ☐ No ☐

2. Is it a referral for a patient who plans to get pregnant? Yes ☐ No ☐

   a) If yes, is she seizure free? _____

   b) When was the last seizure? _____

◯ **There is question about choosing the method of contraception**

◯ **Management of menstruation-related seizures (catamenial seizures)**

◯ **Management of perimenopausal seizures**

- Is the referral for a patient with well-controlled epilepsy, who have had breakthrough seizures in the perimenopausal period? Yes ☐ No ☐

◯ **There is a concern about effects of antiseizure medication on bone health**

Referring Provider: _____ Signature: _____

Phone: _____ Fax: _____