



**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: _____