Referrals to the Kings Epilepsy Surgery pathway (part of the National CESS programme)

CESS Referral Proforma:

- ☐ I would like to refer the patient below for evaluation on the epilepsy surgery pathway including for VNS (referrals accepted from paediatricians and paediatric neurologists). The child and family will be offered an appointment in the epilepsy surgery clinic if accepted onto the pathway.

- ☐ I would like to refer the patient below directly for discussion by the CESS MDT at the epilepsy surgery meeting **(please note this option can only be accepted if referral is made by the regional paediatric neurology service**)

- ☐ I have discussed this referral with the family so that they are aware that they may be contacted directly by the Kings Epilepsy Surgery team.

Name	
Date of birth	
NHS number	
Address	
GP	
Referring Consultant	
Lead Regional Paediatric Neurologist and regional neurosciences centre (if not referrer)	
Reason for referral (see CESS criteria)	
Any significant perinatal history	☐ No ☐ Yes details:
Genetic diagnosis or chromosomal abnormality?	☐ No ☐ Yes details:
Structural abnormality on MRI	☐ No ☐ Yes details:
Details of seizures	
Age of onset	

Is there a history of spasms? **Is there a history of febrile seizures?**		Yes/No. Details if yes: Yes/No. Details if yes:
Seizure type at onset, and subsequent if different from current		
Current Seizures	**Frequency**	
Type 1	☐ **Daily** ☐ **Weekly** ☐ **Monthly**	**Description of seizure (please include details of any aura, clinical features observed and triggers)**
Type 2	☐ **Daily** ☐ **Weekly** ☐ **Monthly**	
Type 3	☐ **Daily** ☐ **Weekly** ☐ **Monthly**	
Is there a history of status epilepticus (please give details)	Yes/No If yes details:	
Have seizures been captured on video EEG telemetry?		☐ No ☐ ***If Yes, please state clearly where this was performed ……..***
Current medication and dose		
Previous medications		

Neurodevelopment	
Developmental milestones: **Motor:** ☐ normal ☐ delayed ☐ plateauing ☐ regression, age: **Language:** ☐ normal ☐ delayed ☐ plateauing ☐ Language regression, age: ☐ Changes in speech, age: **Cognition:** ☐ Typical ☐ Global developmental impairment ☐ Diagnosis of intellectual disability/ learning difficulties, Severity (if known):	**Current skills:** **Language :** ☐ typical for age ☐ delayed/impaired ☐ nonverbal *Expressive skills*: ☐ single word ☐ phrases ☐ sentences *Receptive skills:* ☐ Words ☐ 1 step instruction ☐ 2 step + instructions Motor: ☐ Hemiplegia (right/left) ☐ Bilateral movement disorder (upper limb/lower limb/four limb) ☐ GMFCS/equivalent:
Schooling: ☐ Preschool ☐ Mainstream ☐ Mainstream with EHCP ☐ Special school ☐ Other_____	**Academic progress:** ☐ As expected. ☐ Below level expected ☐ Plateauing ☐ Regression, age: ☐ Specific difficulties ☐ Not known Comments:
Developmental comorbidities: ☐ Autism ☐ Attention Deficit (Hyperactivity) Disorder ☐ Behaviour that challenges ☐ Mood disorders ☐ Anxiety ☐ Other_____	**If over 6, estimate of overall level of functional skills:** ☐ As expected for age ☐ Needing some more support than expected for age eg prompting ☐ Skills at a preschool level- eg needing adult help for self-care ☐ Fully dependent on adults ☐ Unknown
Has the child previously had a formal neuropsychology or developmental assessment?	☐ No ☐ Yes (please send any reports available)
Risk discussions:	Have you had a conversation with family and young person about risk in relation to epilepsy, including risk of SUDEP? Yes No

Safeguarding concerns:	Yes/No If Yes, details:
EEG	Please confirm ☐ All relevant EEG reports enclosed (mandatory information - we cannot process referral without this)
MRI Images (other neuroimaging)	Please confirm ☐ Reports attached (please state Hospital where MRI (s) were performed and date(s)
Genetic investigation performed	☐ No ☐ Yes: all reports attached which tests: ☐ Results pending: which tests:
Other investigations if undertaken: **Please tick as appropriate** ☐ **Metabolic** ☐ **Autoimmune**	Please summarise relevant results:
Any additional relevant information: eg other professionals who should be included in communication	
Email completed form ***together with*** local EEG and imaging reports to **Kch-tr.cesskingsreferrals@nhs.net**	