Norton Neuroscience Institute

Epilepsy Monitoring Unit
Norton Brownsboro Hospital
4960 Norton Healthcare Blvd.
Louisville, KY 40241

Inpatient VEEG Seizure Monitoring Unit Referral Form

Date of Request: _____

Patient Name: _____ DOB: _____/_____/_____

Parent /Guardian (if applicable): _____ Address_____

Phone:_____ Secondary contact: _____

Insurance:_____ Secondary:_____

You must fax the patient demographic sheet and copy of insurance cards (front and back), include any available prior EEG, MRI, or Head CT results and most recent clinic note. FAX- 502 446-8824. Also For any questions please call the Epilepsy Monitoring Unit directly PHONE (502) 446-8399.

Diagnosis Code (Please see attachment for acceptable ICD-10 codes)

By signing this referral form I acknowledge that it is the responsibility of the referring office to obtain insurance authorization and complete any and all preadmission testing (i.e. Covid 19 screening).

Statement of Inpatient Requirement:

*Inpatient monitoring is necessary due to the severe nature of these seizures, and the need to accurately diagnose them to provide the best treatment. Outpatient diagnostic testing is **not able** to capture seizures with sufficient detail and efficiency to achieve this goal. In addition, the need to wean medications and use procedures to enable potentially large seizures requires inpatient care with trained medical staff to ensure accurate monitoring, catchment and characterization of seizures, and ensure patient safety.*

Typical admissions require at least 48 hours, and up to 7 days, to enable safe weaning of seizure medications to increase yield of testing, and to allow time for restarting medication prior to discharge.

Please indicate below if you would like the patient to follow up with your referring office or if you would prefer to transition the patient's care to Norton Neuroscience Institute.

- ☐ Yes
- ☐ No

Please indicate below if you would prefer a detailed report or a disc of the patient's monitoring.

- ☐ Report
- ☐ Disc

I attest that all information above is accurate and applies to this patient:

_____ _____ _____

Referring Physician Signature | Date | Office Phone/Fax

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