SickKids®
THE HOSPITAL FOR
SICK CHILDREN

Epilepsy Classroom Referral Form

The referral of a child to the Epilepsy Classroom at The Hospital for Sick Children can be made by a ***parent, teacher/school, neurologist, pediatrician, family physician or other professional***. When a child is accepted into the Epilepsy Classroom it is crucial that there is a neurologist or pediatrician with whom we can consult and collaborate.

Date of Referral:			
Name of Referring Person and Phone Number:			
Relationship to Child:			
Name of Child:			
Date of Birth:			
Hospital for Sick Children # (if applicable):			
Name of Parent(s): **1)**		Telephone (h)	Telephone (w)
2)		Telephone (h))	Telephone (w)
Home Address			

Please indicate **why you are referring this child to the Epilepsy Classroom:**

Name and Location of Child's Current School

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Please indicate the child's **seizure type(s) and frequency** of seizures:

Seizure Type	Frequency

When was this child's **last seizure**:

Who is this child's **neurologist:**

Does this child have any other **diagnoses (e.g., Learning Disability, Developmental Disability, Autism)**?

Please indicate any **medication and/or other treatment currently being used** to help control the seizures:

Medication/Treatment	Frequency

Does this child have **learning difficulties**? Yes ☐ No ☐

Does this child have **behaviour difficulties**? Yes ☐ No ☐

If the child has had a recent **psychological assessment** please attach it to this referral form.

Please fax this referral form and direct any questions to Elizabeth Kerr (Phone: 416-813-6784, Fax: 416-813-8839). Thank you.