UAB SEIZURE/EPILEPSY MONITORING UNIT REFERRAL

Referring MD: _____
Phone Number: _____ Fax Number: _____
Patient's PCP: _____ Phone Number: _____

Patient Name: _____ DOB: _____
Social Security Number: _____ UAB MRN: _____
Mailing Address: _____
Home Phone Number: _____ Other Phone Number: _____

Primary Insurance Name: _____
Primary Insurance Phone Number: _____
Policy Holder Name: _____ DOB: _____
Relationship to Patient: _____
Policy ID Number: _____ Group Number: _____

Secondary Insurance Name: _____
Secondary Insurance Phone Number: _____
Policy Holder Name: _____ DOB: _____
Relationship to Patient: _____
Policy ID Number: _____ Group Number: _____

Admission to the S/EMU to determine (please complete all applicable fields):
Diagnosis: _____
Does patient have known seizures: YES____ NO____
If yes, seizure type: _____
How many seizures have occured in the last month? _____
Admission for medical adjustment: YES____ NO____
Evaluate for Epilepsy Surgery: YES____ NO____

Please fax H&P, EEG/MRI/CT reports, most recent telephone notes, and most recent clinic notes. **Patient will not be scheduled until all information has been received.** Completion of this form does not provide us with enough information to obtain insurance precertification. Clinical documentation is required. **Please not this is an inpatient services.**

Fax to: Seizure/Epilepsy Monitoring Unit: 205.975.6360
Please call with any questions: 205.934.6418