

Confidential Referral Form

Agency/Service Provider/Health Professional making the referral:

NAME POSITION

ORGANISATION

ADDRESS

PHONE FAX

EMAIL

Person being referred:

NAME DATE OF BIRTH

ADDRESS

PHONE EMAIL SEX M F

If person being referred is a minor, details of the parent/guardian:

NAME RELATIONSHIP

ADDRESS

PHONE EMAIL

Services required: (tick as many as relevant)

- Referral to epilepsy counsellor
- Family support
- General information on epilepsy
- Assistance with development of an Epilepsy Management Plan
- Emergency medication training – Midazolam
- Emergency medication training – Rectal Valium
- Self-help group
- Other _____

Reason for referral/background information:

Consent has been obtained to pass on the personal details of the person being referred and/or their parent/guardian.