

The Center for Epilepsy
Southern Illinois University School of Medicine

Dear _____:

This is a reminder that you have an appointment to be seen by Dr. Evans/Dr. Naritoku at The Center for Epilepsy at the SIU School of Medicine on:

Date: _____ at _____.

(Please refer to last page for EEG Appointment time and instructions, if applicable).

The clinic is located on the third floor at 751 North Rutledge, Room 3100, Springfield, Illinois in the SIU Department of Neurology. Parking is available 1/2 block off of Rutledge on West Miller in the Baylis parking ramp. If this is your first visit to the clinic, a map is enclosed to assist you. (Building A on your map.)

When you come for your appointment, please bring the following:

- A friend or relative who has witnessed your seizure(s) (if first appointment).
- Current medication
- A calendar of seizure activity (form enclosed).
- Previous x-rays and EEG's.
- Questions for the doctor.
- Additional pertinent information (old medical records, etc.).

If you have any questions regarding your appointment time or date, or if you are unable to keep your appointment, please notify the scheduling desk as soon as possible at (217) 545-8417.

In cooperation with The Epilepsy Resource Center of Central Illinois

PLEASE BRING COMPLETED FORM TO YOUR APPOINTMENT

INSTRUCTIONS

1. On the blanks below, describe the types of seizures or spells you have experienced.

Write only one type of seizure/attack on each line.

A. _____

B. _____

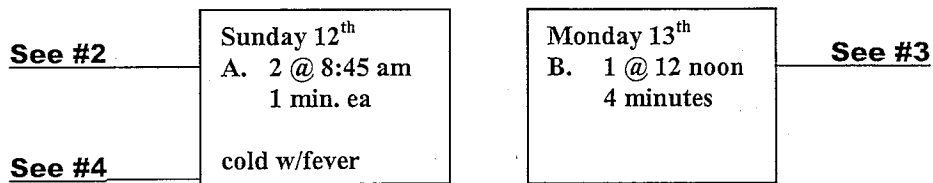
C. _____

D. _____

- Example:**
- a. Staring attacks, unresponsiveness
 - b. Dizzy, vomiting, double vision

2. Write down the letter (A, B, C, and D) on the calendar to represent the type(s) of seizure/spells you have on that day.
3. Place beside each letter the number of times you had the seizure/attack on that day, the time each one occurred, and how long each one lasted.
4. If you think you have other things going on that might have affected your seizures or spells (i.e. fever, colds, missed medications, alcohol consumption, stayed up late, menstruation, etc.), please write these in the bottom of the squares.

Example:



5. Complete SEIZURE CALENDAR on following page.

**THE CENTER FOR EPILEPSY
SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE**

NAME _____

SEIZURE CALENDAR

FOR THE USE OF YOUR DOCTOR ONLY

BIRTHDATE _____

____/____/2005 - ____/____/2005

Weight (Kg) _____

Telephone Number _____

Sunday _____	Monday _____	Tuesday _____	Wednesday _____	Thursday _____	Friday _____	Saturday _____
Sunday _____	Monday _____	Tuesday _____	Wednesday _____	Thursday _____	Friday _____	Saturday _____
Sunday _____	Monday _____	Tuesday _____	Wednesday _____	Thursday _____	Friday _____	Saturday _____

**THE CENTER FOR EPILEPSY
AT SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE**

DATE _____

SIU# _____

MEDICAL/SOCIAL HISTORY

NAME _____

DATE OF BIRTH _____ **AGE ON CLINIC DATE:** _____

ADDRESS: _____

(STREET, CITY, STATE, ZIP CODE, AND COUNTY)

TELEPHONE: HOME: () _____ **WORK:** () _____

LIST PERSONS LIVING IN HOME:

NAME: _____ **AGE:** _____

NAME: _____ **AGE:** _____

NAME: _____ **AGE:** _____

NAME: _____ **AGE:** _____

NAME: _____ **AGE:** _____

NAME: _____ **AGE:** _____

WHO REFERRED YOU FOR EVALUATION?

WHY WERE YOU REFERRED FOR EVALUATION?

WHAT IS IT ABOUT YOUR CONDITION WHAT CONCERNS YOU?

HOW DO YOU THINK THAT WE MIGHT BE ABLE TO HELP YOU? BE SPECIFIC.

IF YOU HAVE SEEN SOMEONE ELSE FOR THESE OR OTHER PROBLEMS, WHO HAS SEEN YOU? (ALSO INDICATE WHEN, AND WHAT YOU WERE TOLD ABOUT THE PROBLEMS)

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST SEIZURE? _____

DESCRIBE: _____

DESCRIBE CURRENT SEIZURES: LENGTH, FREQUENCY OF OCCURRENCE, AND POST-SEIZURE RESPONSE:

MEDICATIONS

ARE YOU PRESENTLY TAKING SEIZURE MEDICATIONS? YES _____ NO _____

PRESENT MEDICATION:

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT GIVEN PER DAY?	AT WHAT TIME IS IT GIVEN?	HOW LONG HAVE YOU BEEN TAKING MEDICATION?
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LAST BLOOD TEST: DATE _____ LOCATION _____

WHAT OTHER SEIZURE MEDICATIONS HAVE YOU TAKEN?

MEDICATION	DOSAGE	HOW LONG DID YOU TAKE THIS MEDICATION?
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WHAT IS THE LONGEST PERIOD YOU HAVE BEEN SEIZURE FREE? _____

WHAT MEDICATION(S) WERE YOU TAKING DURING THIS PERIOD? (INCLUDE DOSE)

DIAGNOSTIC TESTING

DATE _____ LOCATION _____

_____ **EEG** _____

_____ **CT SCAN** _____

_____ **OTHER** _____

HOSPITALIZATIONS

REASON _____ **DATE** _____ **HOSPITAL** _____

DESCRIBE OTHER MEDICAL PROBLEMS _____

LIST KNOWN ALLERGIES AND SENSITIVITIES _____

WAS THERE ANYTHING UNUSUAL ABOUT YOUR BIRTH OR MOTHER'S PREGNANCY?

CHILDHOOD ILLNESSES, ACCIDENTS, HOSPITALIZATIONS _____

INDICATE ANY MEDICAL PROBLEMS, ETC. FOR THE FOLLOWING:

FATHER _____

MOTHER _____

SIBLINGS _____

PATIENT'S EMPLOYMENT

PRESENT OCCUPATION _____

PAST EMPLOYMENT _____

ANNUAL INCOME _____

ARE YOU RECEIVING?

SOCIAL SECURITY DISABILITY INCOME? YES NO

SUPPLEMENTAL SECURITY INCOME? YES NO

YEAR DETERMINED ELIGIBLE _____

ARE YOU A CLIENT OF ILLINOIS DEPARTMENT OF REHABILITATIVE SERVICES?

YES NO

ARE YOU PRESENTLY IN A JOB TRAINING PROGRAM? YES NO

IF YES, WHERE? _____

ARE YOU PRESENTLY A CLIENT OF ANOTHER COMMUNITY SERVICE AGENCY?

YES NO

IF YES, WHAT AGENCY? _____

**Center for Epilepsy
Appointment Policy**

1. **The patient must have a referral from a physician.**
2. **The reason for the referral should be epilepsy related.**
3. **Medical records should be forwarded or brought with the patient to the appointment.**
 - a. **Patient is responsible for collecting medical records.**
 - b. **Group facilities need to compile all past records. NO EXCEPTIONS!**
4. **Determine where and when the last EEG was done. An EEG will be scheduled for the patient if the EEG test was not at Memorial Medical Center or St. John's Hospital within the last six months.**
5. **Determine if a CT or MRI has been done. If so, the patient should bring these films to the appointment if at all possible.**
6. **Patient, family and/or facility/group home needs to understand the following requirements:**
 - a. **MUST keep a seizure record.**
 - b. **MUST be accompanied for the initial appointment by a person who has witnessed the seizure and is prepared to describe this to the doctor.**
 - c. **MUST know present medication and how the medication is being taken. The patient, family, or facility should be able to tell the doctor about past medications.**

The treatment of epilepsy is a process that often takes time and patience, especially if reducing or changing medications. Treatment is a collaborative effort on the part of the patient and the neurologist. The records and information presented to the doctor are very important for successful treatment.



Memorial Medical Center

INSTRUCTIONS FOR OUT PATIENT EEG PROCEDURES

An appointment has been made for _____ on _____ at _____ a.m. _____ p.m. to have an EEG. Please report to the Main Lobby of Memorial Medical Center on First and Miller Streets, approximately 15 minutes prior to your appointment time. After registration, you will be directed to the "LINCOLN ELEVATORS", proceed to the **THIRD FLOOR** Clinical Neurophysiology Laboratory. (When getting off of the elevator on the third floor turn to your right).

If you must cancel your appointment, let us know at least 24 hours in advance, but if this is impossible, please notify us as soon as possible at (217) 788-3911.

We would like you to sleep in order to obtain accurate test results. The time required for the test depends on how quickly you can fall asleep.

- 60 + YEARS:** Try to stay awake all night. Please don't compromise your health and well being, but try to come in tired and sleepy.
- 18 - 59 YEARS:** Up all night.
- 10-7 YEARS:** Up all night,. May nap from 9:00 PM - 12:00 midnight.
- 5 - 9 YEARS:** Stay up until 11:00 PM and awoken at 4:00 AM.
- 1 - 4 YEARS:** Put your child to bed 3 hours after normal bedtime. Wake 2 hours before normal wake time. Bring sleep aids. (pacifier, etc.)
- 7 - 11 MONTHS:** Put baby to bed 2 hours after their normal bedtime. Wake 2 hours before normal wake time. Bring morning bottle to have during the EEG. Bring diapers, sleep aids (pacifiers, etc.)
- 4 - 6 MONTHS:** Put baby to bed 2 hours after their normal bedtime. Wake 2 hours before normal wake time. Please plan on giving his/her morning bottle during the EEG. Bring diapers, sleep aids (pacifiers, etc.)
- 0 - 3 MONTHS:** Using parental discretion, please bring your baby in sleepy; bring bottle, diapers, sleep aids (pacifier, etc.)

If your child is accustomed to sleeping with a "special" stuffed toy or blanket, feel free to bring them. We encourage parents to stay with young children during the entire procedure.

MEALS: You may have regular meals; however, please avoid any stimulants such as coffee, tea or caffeinated beverages prior to testing.

MEDICATIONS: Take all regular medications..

HAIR: Please shampoo hair before arriving for the test. Hair should be clean and free from grease, oil or hairspray and gels.

PARKING: Parking is available on First and Miller Streets in the Visitor Parking Lot.