UAB Seizure/EpilepsyMonitoringUnit Referral

Referring M.D. _____
Telephone # _____ Fax # _____
Patient's PCP _____ Telephone # _____

Patient Name _____ DOB _____
Social Security # _____ UAB MRN _____
Mailing Address _____
Home Telephone # _____ Other # _____

Primary Insurance Name _____
Primary Insurance Telephone # _____
Policy Holder Name _____ DOB _____
Relationship to Patient _____
Policy ID # _____ Group # _____

Secondary Insurance Name _____
Secondary Insurance Telephone # _____
Policy Holder Name _____ DOB _____
Relationship to Patient _____
Policy ID # _____ Group # _____

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 occurred in the last month? _____
Admission for medication 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 is received.*** Completion of this form does not provide us with enough information to obtain insurance precertification. Clinical documentation is required.
Please note: This is an in-patient service.

Fax to: Seizure/Epilepsy Monitoring Unit: (205) 975-6360
Please call with any questions: (205) 934-6418