Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston
Hôpital Hotel Dieu Hospital
KGH Hôpital Général de Kingston General Hospital

EPILEPSY MONITORING UNIT (EMU) REQUISITION

Phone: 613-548-7835 (EEG, Connell 7, KGH)
Fax: 613-548-2451
Download form https://khscnow.kingstonhsc.ca/emu

PATIENT INFORMATION

Name _____

DOB (yyyy/mm/dd) _____

CR _____ Visit#_____

OHIP _____

Telephone _____

Date Received (yyyy/mm/dd) _____ Time (hhmm) _____ EMU Date (yyyy/mm/dd) _____

Diagnosis: ☐ Epilepsy ☐ Spells ☐ Not yet determined **Epilepsy**: ☐ Focal onset ☐ Generalized ☐ Unclear

If Epilepsy, predominant seizure type:
☐ (a) focal aware
☐ (b) focal with impaired awareness
☐ (c) generalized tonic-clonic seizures
☐ (d) other _____

Current frequency of seizures / spells type: (a) _____ (b) _____ (c) _____ (d) _____

Any generalized tonic-clonic seizure experienced?: ☐ Yes ☐ No Aura usual?: ☐ Yes ☐ No

Duration of Epilepsy / spells : _____ years
Any violent behaviour concerns? ☐ Yes ☐ No ☐ Unknown _____
Do spells involve dizziness/vertigo/altered consciousness that may lead to a fall? ☐ Yes ☐ No ☐ Unknown

Current anti-seizure medications: _____
_____

Anti-Seizure Medications (ASM) to be tapered during admission: ☐ Yes ☐ No

ASM tapering plan: _____
_____

Significant co-morbidities: ☐ Psychiatric ☐ Cognitive ☐ Cardiorespiratory ☐ Sleep (apnea/parasomnias)
Other pertinent medications: _____
Regular use of: ☐ Alcohol ☐ Nicotine ☐ Cannabis

Purpose of admission:
☐ Pre-surgical evaluation for refractory focal epilepsy (localization)
☐ Classification of focal versus generalized epilepsy
☐ Confirmation of diagnosis of non-epileptic events
☐ Assessment of current seizure burden (patient living alone, seizures mostly in sleep, unexplained episodic cognitive impairment)
☐ Medication optimization for refractory epilepsy
☐ Documentation of new seizure type
☐ Other _____

Additional electrodes: ☐ Temporal lobe ☐ Invasive ☐ Electro-oculogram (EOG) ☐ Other _____
Sleep deprivation recommended: ☐ Yes ☐ No
Diagnostic Imaging: 3T MRI required: ☐ Yes ☐ No

Expected length of EMU admission (to be discussed with patient): _____ days
Family member/caregiver available to stay with patient in EMU?: ☐ Yes ☐ No

REFERRING PHYSICIAN Printed Name _____

Date (yyyy/mm/dd) _____ Time (hhmm) _____ **Physician Signature** _____