UR Medicine Epilepsy Center Admission Request

Phone: (585)275-3681/ Fax: (585)442-4329

UR/Strong Memorial Hospital
601 Elmwood Ave; Box 673
Rochester NY 14642

Admission date:_______________@_________

SMH MR#: ________________________

Patient Name: _________________________________ DOB: ________________

Person to call to schedule (if other than patient):_____________________________ Phone #: ____________________

Neuro MD: ___________________________________ PCP: ____

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Patient History: (*MUST BE COMPLETED*)

*Description of events: ____

*Frequency of events: ____

*Current anti-seizure meds: ____

*Outpatient EEG/result: ____

*Imaging/results: ____

Reason for admission:

- ☐ Characterization of seizure
- ☐ Evaluate for Epilepsy surgery
- ☐ Evaluate for subclinical seizures
- ☐ Suspected psychogenic events
- ☐ Other: ____________________

Concerns/Notes:______________________________

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MD signature:____ Date: _______________________________

Office contact name: ____________________________________ Phone #: ____________________________

Revised Oct 2016