

# Non-Epileptic Seizure (NES)/Functional Seizure (FS) Clinic

Email: [ucdnesclinic@ucdenver.edu](mailto:ucdnesclinic@ucdenver.edu)

Phone: 720-848-2080

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## Referral Form

### Patient Information

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date Referred: \_\_\_\_\_ Insurance carrier: \_\_\_\_\_

### NES/FS Diagnosis and Description

Description of  
NES/FS: \_\_\_\_\_

Definitive NES/FS Diagnosis? YES NO If yes, diagnostic EEG required.  
 (v-EEG capture of typical NES/FS)

Probable NES Diagnosis? YES NO If yes, does patient have a home video? YES NO  
 (Normal interictal EEG and home video capture of NES/FS)

**\*\* Report of normal interictal EEG is required. Referral for patients with no EEG report or pending evaluation will be declined. If Clinically Possible, video of typical NES is also required. \*\***

NES/FS diagnosis discussed with patient? YES NO

Referral to NES/FS Clinic discussed with patient? YES NO

Patient is accepting of NES/FS diagnosis? YES NO

If no, explain: \_\_\_\_\_

### NES/FS – Diagnosing Clinician and EEG Location

Date of NES/FS diagnosis: \_\_\_\_\_ Event captured? YES NO

NES/FS diagnosing clinician: \_\_\_\_\_

Location of diagnostic/normal EEG: \_\_\_\_\_

Phone number: \_\_\_\_\_ (NDX Department)

### Referring Provider Information

Name: \_\_\_\_\_  
Institution: \_\_\_\_\_ Department: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Required Medical Records Checklist

**PLEASE NOTE – WE WILL NOT ACCEPT YOUR PATIENT WITHOUT THESE MEDICAL RECORDS. REFERRING PROVIDER IS RESPONSIBLE FOR LOCATING AND SENDING THESE TO NES/FS CLINIC**

EEG Report ☐ \*required

Brain MRI/CT ☐ \*required

If patient has home video, please upload or request patient upload home video using this link or by following directions below: <https://neurologyevent.ucdenver.edu/nas/upload>

#### Upload Video Instructions:

1. Navigate to NES Clinic website: [www.nestreatmentucd.org](http://www.nestreatmentucd.org)
2. Click "UPLOAD VIDEO" on the home page
3. Enter email, patient's first and last name
  - a. For company, enter "Self" if patient uploading, enter "Provider" if provider is uploading.

### FAX THIS FORM WITH MEDICAL RECORDS TO:

Fax: (720)-848-2106  
ATTN: Non-Epileptic Seizure (NES) Clinic

\*\* To expedite referral, email NES/FS Clinic Program Manager: [Meagan.watson@cuanschutz.edu](mailto:Meagan.watson@cuanschutz.edu)