Adult Care Team Provider Referral Form

The next conversations can be around connecting your current care team with the new care team to ensure your new adult care team has all the information and history they need to continue the best possible care for your loved one with rare epilepsy. Consider starting with your child's primary care provider and neurologist or epileptologist. Once you have this task completed, depending on your experience thus far, you may choose to alter the list of questions identified above or adjust the process to accommodate the needs of your loved one with rare epilepsy. Ask your child's adult neurologist or epileptologist and adult primary care provider, as well as your child's other medical care team, to provide you with recommendations for the rest of the specialists and others who care for your child. Make note of the information using the form below. Refer to the Attachments section for additional referral forms.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.

Specialty:

Provider Name: Hospital Affiliation:

Address:

City: State: Zip:

Phone: Mobile:

Email:

Does this adult physician have a collaborative working relationship with your pediatric provider? ☐ YES ☐ NO

Note your observations/notes below about this provider after you connect with them.