epilepsy south eastern ontario

Emily's Fund Client Intake Form

Date: _____

Client Information

Name: _____ Male ☐ Female ☐

Address: _____

City/Province: _____ Postal Code: _____

Age Group: ☐ 0-12 ☐ 13-18 ☒ 19-64 ☐ 65+ DOB: _____

Phone: _____ Email: _____

Relationship:
☐ Self ☐ Parent ☐ Partner
☐ Friend/Co-worker ☐ Employer ☐ School/Teacher
☐ Other: _____

Referred to the Epilepsy South Eastern Ontario by: _____

Medical History (self)

Age: _____ Family Physician: _____
Neurologist: _____

Type of Seizure(s):
☐ Tonic Clonic ☐ Absence (PM) ☐ Myoclonic ☐ Atonic
☐ Focal dyscognitive (CP) ☐ Focal without impairment of consciousness (SP)
☐ Non-epileptic ☐ Unknown; please describe:

Medical history:

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Reason for Contact:
Please check all that apply:

☒ Support ☒ Information ☐ Education ☐ Financial
☐ Employment ☐ Driving ☐ Newly Diagnosed ☐ Epilepsy Clinic
☐ Other; please specify:

Psychosocial History:

Comments:

Follow Up: _____

For Office Use Only

Handouts Provided:

Referrals:

Time spent on initial contact: min. _____

Staff Signature: _____

Date: _____

Level of service: ☐ Crisis (5) ☐ Counselling (4) ☒ Structured (3)
☐ Informal support/resources (2) ☐ Public awareness/education (1)

Add to Mailing List: ☐ Email ☐ Mail ☐ None