Epilepsy new patient form/intake form (to be kept in patient file at clinic)

Facility		**County/Country**		**Date**	

1. Sociodemographic information

Patient's Name		DOB/Age		Gender	
Date of first visit		File No./Reg. No.		Education	
		Position of child in the family			
No. of Siblings		No. alive		No. dead		Birth order	

Parents' data

Father's Name		Age	
Occupation		Education level	
Mother's Name		Age	
Occupation		Education level	
Guardian/Caretaker		Address	
Caretaker relationship to patient		Phone No.	

Residence

Address		Phone No.	
State/County		Payam & Boma	
Zone	Rural ☐ Urban ☐	Distance from health facility	Km: ___ Hours: ___

2. Seizure/epilepsy related history

Reason for visit/ presenting history	
Type of epilepsy	a. Focal ☐ b. Generalized ☐ c. Combined generalized and focal ☐ d. Unknown ☐
Etiology of symptomatic epilepsy	a. Birth injury/asphyxia ☐ b. Meningitis/encephalitis ☐ c. Measles/malaria ☐ d. Accident ☐ e. Tumor ☐ f. Other or unknown disease ☐ g. Febrile convulsions ☐ h. Others ☐
Type of seizure	a. Generalized seizures: 1. Tonic-clonic ☐ 2. Atonic ☐ 3. Absences ☐ 4. Myoclonic ☐ 5. Clonic ☐ 6. Tonic ☐ b. Focal seizures: 1. Motor ☐ 3. Visual ☐ 2. Somatosensory ☐ 4. Hearing ☐ 5. Emotional ☐ c. Focal seizures with secondary generalization ☐
Age at seizures onset	Date of last seizure
Seizure frequency	a. Daily ☐ b. Weekly ☐ c. Monthly ☐ d. Occasionally ☐
Seizure description	
Onset of seizures	a. Only with fever ☐ c. Only without fever ☐ b. With fever and without fever ☐
Trigger to seizure	i. Alcohol ☐ ii. Pregnancy ☐ iii. Menstruation ☐ iv. Photo stimulation ☐ v. Cold whether ☐ vi. Fever/stress ☐ vii. Food ☐ viii. Others ☐
Birth conditions	a. Normal ☐ c. Cesarean Section ☐ b. Difficult ☐ Discuss if abnormal, _____
Past antiepileptic treatment history *(name, dosage, daily intake)*	
Present antiepileptic treatment *(name, dosage, daily intake)*	
Epilepsy in family, Other relevant medical history	

3. Onchocerciasis related history

Previous Ivermectin intake					
Frequent itching	Yes ☐ No ☐	Blurred vision	Yes ☐ No ☐	Ever diagnosed for onchocerciasis	Yes ☐, When_____ No ☐

4. Physical examination

BP		PR		RR		Temp (°C)		Wt. (kg)	
Height (cm)		MUAC (cm)		Head circumference	
Chest		HEENT (Head, ear, eye, neck, throat)	
Milestones		Nervous system	
Abdomen		Mental impairment	
Genitourinary system:		Traumatic lesions:	
Integumentary system:		Burns or scars of burns:	
Musculoskeletal system:		Physical impairment (specify):	

5. Quality of life

Ability to perform at school	a. Normal ☐ c. Moderately affected ☐ b. Unable ☐ d. If abnormal, describe_____
Ability to work at home or in the farm	a. Normal ☐ c. Moderately affected ☐ b. Unable ☐ d. If abnormal, describe_____

6. Assessment for nodding syndrome/Classification for nodding syndrome[1]

a. Probable case of NS *(A Probable Case of NS meets major criteria **i, ii** and **iii** + at least one minor criterion between **iv – ix**)*	i. Head nodding? Yes ☐ No ☐	Reported ☐ Videotaped ☐ Observed by HW ☐
	ii. Age at onset of nodding between 3 - 18 yrs old	Yes ☐ No ☐ If yes, what age? _____
	iii. Frequency of nodding 5 to 20 per minute	Yes ☐ No ☐
	iv. Other neurological abnormalities	Yes ☐ No ☐ If yes, specify: _____
	v. Clustering in space or time with similar cases	Yes ☐ No ☐ Any siblings? _____
	vi. Triggered by food and/or cold weather	Yes ☐ No ☐ If yes, by what? _____
	vii. Stunting or wasting (*see Section 7*)	Yes ☐ No ☐ If yes, specify: _____
	viii. Delayed sexual or physical development	Yes ☐ No ☐
	ix. Psychiatric symptoms.	Yes ☐ No ☐ If yes, specify: _____
b. Confirmed case of NS *(if both criteria **x** and **xi** are met)*	x. Probable case? (*see above*)	Yes ☐ No ☐
	xi. documented nodding episode (*observed by trained health worker, Videotaped, or by EEG/EMG*)	Yes ☐ No ☐ If yes, specify: _____

7. Nutritional assessment a. SAM ☐ b. MAM ☐ C. Normal ☐

8. Laboratory findings

Skin snip for onchocerciasis		Malaria test	
OV16 serology		Hemoglobin	
Salmonella Test		Others	

9. Referral pathway / Referred by

a. Came by family initiative ☐
b. Referred by health facility ☐
c. Referred by CHW/CBRW or Org ☐

If (c), Client Code:_____
Referral Form SN: _____
CHW/CBRW name:_____
Organization:_____

10. Other relevant information

11. Diagnosis

12. Treatment initiated *(name, dosage, daily intake)*

13. Epilepsy education done Yes ☐ No ☐

14. Referred for Follow-up? Yes ☐ No ☐ If Yes, specify: CHW / CBRW name:_____
Organization:_____

15. Next appointment Date _____ Day _____

16. Name and signature of health personnel

_____ Name

_____ Signature

[1] World Health Organization. International Scientific meeting on Nodding Syndrome. Kampala, Uganda; 2012.