Referral To: KB HSC ..... Hospital Date 4/5/96

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Consultant ..... Department .....

Please arrange:

Emergency Admission
Normal / Urgent / Semi Urgent Appointment for O.P Clinic/
Domiciliary Visit.

Details of Patient:

Surname Roberts Mr./Mrs/Miss

Forenames Clare

Previous Surname

Address [redacted]

Postcode:

Date of Birth 6 | 1 | 87

Occupation

Phone No. 797745

Hospital Number:

Date of Last Attendance at this Hospital .....

Date of Last Attendance at any other Hospital .....

Name of Hospital:

Reason for Referral 9yr old girl with severe learning disability and partially sighted ? epilepsy

History/Examination: Fit free for 3 yr - weaned off epilepsy 18 mths ago
No speech since coming home
very lethargic at school today
vomited x 3 - Speech slurred
Speech slurred earlier
Pale, pupils reacty - does not like light
No neck stiffness, Temp
Tone ↓ R side plantar ↑↑ ↓ plantar ↓↓

Provisional Diagnosis: ENT - NFND

Past History:

Present Medication: Chest clear
nil

Known Allergies: ? Further fits
? underlying infection

Other Relevant Information: I would appreciate your opn

DOCTOR'S OR PRACTICE STAMP

Castlereagh Medical Centre
220 Knock Road
Belfast
BT5 6QF
Tel. 0232 798308

Doctors Signature ..... (Cypher No.) E990

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CR – RVH

090-011-013