**[](http://connect/)**

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| **Ketogenic Dietary Therapy Referral Form**  Please email this completed form and the latest clinic letter to [BRHCketodietitians@uhbw.nhs.uk](mailto:paedketodietitians@uhbw.nhs.uk) | |
| **To be considered for ketogenic dietary therapy, the patient must meet the following referral criteria:**   * The patient has tried 2 AEDs or has one of the following conditions: Glut-1 deficiency syndrome, Pyruvate Dehydrogenase deficiency, Lennox-Gestaut syndrome, Infantile spasms syndrome or epilepsy with myoclonic-atonic seizures (Doose syndrome). * The referral has been approved by a named BRHC Neurology Consultant. * The patient is under 18 years old. | |
| **Please complete the following to enable us to prioritise this referral:**   1. Diagnosis: 2. Number of current anti-seizure medications: 3. Prior number of anti-seizure medications tried: 4. Previously tried ketogenic dietary therapy: Y/N 5. Previous number of epilepsy related PICU admissions: | |
| **K. Vita**  Can K. vita can be considered as an alternative option if fails to establish KDT: Y/N | |
| **Patient Information** | |
| **Patient Name:** | **Name of local consultant:** |
| **Tel:** | **Name of referrer:** |
| **D.O.B.:** | **Job role of referrer:** Choose an item. |
| **NHS No:** | **BRHC Neurology Consultant:** |
| **Language spoken if not English:** | **Date of referral:** |
| **Any other information useful for this referral:** | |