### SEIZURE REFERRAL GUIDELINE

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

### HIGH RISK

**SUGGESTED EMERGENT CONSULTATION**

**SYMPTOMS AND LABS**
- First Seizure

**EXAM:**
- Should be normal or unchanged from baseline

**SUGGESTED PREVISIT WORKUP**
- Please rule out syncopal convolution and check orthostatics if indicated
- Please obtain prior ER reports and acute imaging, and any EEG data performed outside of MMC/MMP including EEG tracings, if able
- Initial ER visit indicated most of the time for assessment of new onset seizure and then urgent outpatient neurology consult if patient back to baseline

**LABS:**
- EKG, CBC, electrolytes, tox screen and blood EtOH (if warranted)

### MODERATE RISK

**SUGGESTED CONSULTATION OR CO-MANAGEMENT**

**SYMPTOMS AND LABS**
- Active alcoholics with withdrawal seizures
- Seizures with known cause and patient on appropriate medications are less urgent
- Second opinion epilepsy referrals are NOT urgent.
- Chronic epilepsy

**EXAM:**
- Should be normal or unchanged from baseline

**SUGGESTED WORKUP**
- Make sure we have all prior neurology records and test results including EEG, MRI, PET scans, Neuropsych tests
- If chronic patients are controlled, indicate reason for referral to help us prioritize
- If patient has a neurologist, indicate if this is transfer of care or testing only

**LABS:**
- Any recent blood AED levels.

### LOW RISK

**SUGGESTED ROUTINE CARE**

**SYMPTOMS AND LABS**
- Suspected syncope (we can do EEG test only)
- Patients with active polysubstance abuse with symptomatic seizures
- Seizures triggered by hypoglycemia or known metabolic derangement
- Chronic stable epilepsy. Patient requesting 3rd/4th opinions

**SUGGESTED MANAGEMENT**
- Complete abstinence from drugs or EtOH, correct metabolic derangements
- If patient has chronic epilepsy, is seizure free on stable medications and has no reason to consider changing medications, they can be managed by PCP. We can provide phone support if questions arise such as screening for chronic toxicity
- Test only EEG, ambulatory EEG and inpatient monitoring is available for patients with competent neurologists

**LABS:**
- Tox screen positive

### CLINICAL PEARLS

- Syncopal convolution is the most common diagnosis mistaken for seizures and requires careful history. Cardiology referral often indicated.
- Please ensure all prior neurologic records and testing is available before the consult.