39445
Faxed 7/8/08
10:37 am

Kennedy Krieger Children's Hospital

CONSULTATION REQUEST AND REPORT FORM

TYPE OR PRINT FIRMLY - YOU ARE MAKING THREE COPIES

Referral Date 7/8/08

TO DR. _____ Neurology
(Consultant) (Specialty or Clinic)

When Needed? ■ < 24 Hrs.; ■ 24-72 Hrs.: ■ > 72 Hrs.

Haya Al-Yasin

12-19-03
KKI 12-19-03 1479710012
AL YASIN, HAYA
JHH 8 4536149
6/09/03 A F 0030
F 7/07/08 832 0

To be completed by REQUESTING PHYSICIAN:

1. Primary Problem: Seizure disorder

2. Other Relevant Problems: H/o astrocytoma, s/p resection and VP shunt

3. Questions to Be Answered: Proper management / medications.

Mark Kelly
(Requesting Physician's Signature)

KKI-3
(Requesting Clinic or Nursing Unit)

CONSULTANT'S FINDINGS

CONSULTATION DATE: _____

(If more space is needed for this report, use Consultation Report-Continuation Sheets. Consultant's signature should appear at the end of the report.)

CONTINUATION SHEET(S) ATTACHED ■

Form # 875/1002/0/12-93