UF | UNIVERSITY of FLORIDA

College of Medicine
Department of Pediatrics
Division of Pediatric Neurology

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Precision Ketogenic Therapy Referral Form

Name of patient: ______________________________

Date of Birth: ______________________________

Height: ____________________ **Weight**: ____________________

Gender: ______________________________

Epilepsy diagnosis and CPT/ ICD-10 (circle below or may write here)

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Examples of Diagnosis would be (may circle):

Partial Epilepsy, Generalized Epilepsy, Lennox Gastaut Syndrome, GLUT1 Deficiency, Alternating Hemiplegia of childhood, Tuberous Sclerosis, Traumatic Epilepsy, Epilepsy to Hypoxic Ischemic encephalopathy, Epilepsy related to prematurity, Epilepsy related to congenital infection, Infantile Spasms, Ohtahara Syndrome, West Syndrome, Unknown Epilepsy, Epilepsy due to genetic mutation

Does your child have a known genetic mutation (if so, list)? ____________________

Pediatrician: ____________________ Address: ____________________

Phone: ______________________________

Neurologist: ____________________ Address: ____________________

Phone: ______________________________

Insurance: ______________________________

Parents Name(s): ______________________________

Address: ____________________ (city, state) ____________________

Phone: ____________________ Email: ____________________

Fax to UF Pediatric Neurology

Attn: Mary

Phone 352-273-8920

Fax: 352-294-8067