NYSDOH Epidiolex® Expanded Access for Treatment Resistant Epilepsy Study Referral Form

GENERAL PATIENT INFORMATION

Date of Request: _____/_____/_____ **DOB:** _____/_____/_____ **Age:** _____ **Gender:** Male ○ Female ⊙

Patient S.S. # (Last 4 digits):_____

Patient Name: _____ **Parent/Guardian name:** _____

Address: _____ **Address (if different):**_____

_____ _____

Primary Phone #:_____ **Secondary Phone #:**_____

REFERRING PHYSICIAN CONTACT INFORMATION

Referring Physician: _____ **Email:**

Address: _____

Phone Number: _____ **FAX:** _____ **License #:**_____

PATIENT ELIGIBILITY QUESTIONS FOR REFERRING PHYSICIAN

Diagnosis: _____

Number of countable seizures*: _____/week _____/month
*non-countable includes absence and myoclonic (see appendix B)

Does this patient meet all of the Inclusion Criteria and none of the Exclusion Criteria in appendix C? YES ○ NO ○

Is this patient eligible for a GW Pharmaceutical Randomized Controlled Trial? YES ○ NO ○

Is an electroencephalographic (EEG) video monitoring report documenting a typical seizure attached? YES ○ NO ○
(Such a report is required for submission with this form, a video showing a typical seizure is required upon request)

Has this patient been on stable levels of 1-4 Antiepileptic Drugs (AEDs) for a minimum of 4 weeks? YES ○ NO ○

List the name and dose of each AED:

Does the patient have a Vagus Nerve Stimulator (VNS)? YES ○ NO ○
If so, have the settings been stable for at least 3 months? YES ○ NO ○

Is the patient on a ketogenic diet? YES ○ NO ○
If so has it consisted of a stable ratio for at least 3 months? YES ○ NO ○

Will the patient be able to travel to the study site for clinical visits? YES ○ NO ○

Is a daily seizure diary being maintained for the patient? YES ○ NO ○
(a 30 day seizure diary for review by the Principal Investigator is required at the time of clinical evaluation)

PREFFERED STUDY LOCATION **(Choose only one)**

New York Langone Medical Center ○	**Mount Sinai** ○	**Montefiore** ○	**U. Rochester** ○	**U. Buffalo** ⊙
(Dr. Orrin Devinsky)	(Dr. Harriet Kang)	(Dr. Sheryl Haut)	(Dr. David Wang)	(Dr. Arie Weinstock)
NYSCBDInquiry@nyumc.org	pmcgoldr@chpnet.org	shaut@montefiore.org	FAX referrals: (585) 276-2970	melgie@kaleidahealth.org
Maria Hopkins, RN Senior Research Coordinator NYU Comprehensive Epilepsy Center 223 E 34th St. New York, NY 10016	Pediatric Neurology Suite 102 141 South Central Ave Hartsdale, NY 10530	Sheryl Haut, M. D. Montefiore Medical Center 111 East 210th St. Bronx, NY 10467	U. of Rochester Medical Center Child Neurology 601 Elmwood Avenue, Room 5-5517 Box 631 Rochester NY 14642 Attn: Amy Vierhile	Mary Jo Elgie Women & Children's Hospital of Buffalo Department of Neurology Room 762 219 Bryant Street Buffalo, NY 14222

REFERRING PHYSICIAN ATTESTATION

☐ I certify that I am the primary neurologist responsible for directing the treatment of this patient for his / her seizure disorder and the information provided herein is true and accurate to the best of my knowledge.

☐ I certify that I have discussed the clinical study with the patient and/or their parent(s)/legal guardian (as appropriate). He/she/they have agreed in principle to participate if chosen but understand they will have the opportunity to further discuss the study with the Principal Investigator and if selected will need to provide written consent, as administered by the study site, to participate in the study.

☐ I certify that I have obtained and retained written permission from the patient and/or their parent(s)/legal guardian (as appropriate) to forward a study referral form to the chosen epilepsy center and to forward to the NYS Department of Health, de-identified information that will be used to randomly select patients for this study. Such data is to consist of the last four numbers of the patient's social security number, the patient's gender and year of birth as well as the requested study site.

Signature: _____

Date: _____

Note: This form is to be submitted to *one* clinical site only (see above for addresses). Do **NOT** send this referral form to the NYS DOH.