DR A A JALLOH
PAEDIATRIC NEUROLOGIST INC.
011 431 2051 | 067 450 5891
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General Paediatric Neurology Referral

Complete the clinically relevant fields only. Send using your organisation's approved secure method to receptionist@draajalloh.com.

ROUTINE REFERRAL URGENT: use established telephone liaison and acute-care pathways

1. CHILD AND CAREGIVER

Child's full name	**Date of birth** YYYY-MM-DD
Caregiver full name	**Relationship**
Mobile number	**Email**
Residential area	**Medical aid and member number** if applicable

2. REFERRER

Referring clinician name and professional role	**Practice number**
Practice or facility	**Telephone**
Email for secure report	**Preferred contact**

3. REFERRAL QUESTION

[ ] Seizures / epilepsy	[ ] Development / regression
[ ] Cerebral palsy / spasticity	[ ] Hypotonia / weakness
[ ] Movement / tics / ataxia	[ ] Headache / migraine
[ ] Sleep-related concern	[ ] Neurogenetic / complex neurology
[ ] Other: _____	[ ] Second opinion / follow-up

Primary clinical question and reason for referral

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3. REFERRAL QUESTION - CONTINUED

History and time course
Include onset, progression, frequency, triggers, recovery and functional impact.

Relevant examination findings

4. IMPORTANT CLINICAL INFORMATION

Current medicines and doses

Allergies

Relevant pregnancy, birth, development, family and medical history

Previous investigations and results
EEG, MRI/CT, laboratory, genetic, cardiac, sleep or other relevant studies.

[ ] Reports attached	[ ] MRI/CT images available
[ ] School/therapy reports attached	[ ] Safe event video available

5. URGENCY, CONSENT AND SIGNATURE

If prioritisation is requested, give the specific clinical reason
This form is not monitored as an emergency channel.

I confirm that this referral is clinically appropriate, the information is accurate to the best of my knowledge, and the caregiver has been informed of the referral and information sharing.

Referrer signature

Date
YYYY-MM-DD

SEND receptionist@draajalloh.com **ENQUIRIES** 011 431 2051 | WhatsApp 067 450 5891