Date: [Date]

To: [Referring Physician Name]
Clinic: [Referring Clinic Name]
Address: [Referring Address]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Date of Consultation: [Consult Date]

Dear Dr. [Referring Physician Last Name],

Thank you for requesting a neurology consultation for [Patient Name] regarding a suspected seizure disorder.

History of Presenting Illness

[Describe the event, including onset, duration, motor activity, loss of consciousness, and post-ictal state. Note any triggers or prodromal symptoms.]

Medical and Family History

[List relevant past medical history, birth history, and family history of epilepsy or neurological disorders.]

Medications

[List current medications and dosages.]

Physical and Neurological Examination

Mental Status: [Findings]
Cranial Nerves: [Findings]
Motor/Strength: [Findings]
Reflexes: [Findings]
Coordination/Gait: [Findings]

Assessment

[Summary of clinical findings and suspected seizure type, e.g., Focal vs. Generalized.]

Plan

- **Diagnostics:** [EEG, MRI Brain, Labs]
- **Treatment:** [Medication started/changed, dosage instructions]

- **Safety Precautions:** [Driving restrictions, water safety, seizure first aid]
- **Follow-up:** [Timeline for next appointment]

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Contact Information]