NOTIFICATION FORM FOR EPILEPSY DEATHS REGISTER

Name of the patient : ………………… *Maiden name :* ………………… *First Name :* ……………………….

Date of birth : |__|__| |__|__| |__|__|__|__| *Sex :* M ☐ F ☐

Name, address and phone number of the close relation having indicated the death (Specify the family ties) :

Name :……………………………………….. ☎ : |__|__| |__|__| |__|__| |__|__| |__|__|

✉ : ……………………………………………………………………………… |__|__|__|__|__|…………………

CIRCUMSTANCE OF THE DEATH

Date of death : |__|__| |__|__| |__|__|__|__| Presumed ***Hour*** : _ _ h _ _.min ***Municipality***(+Department) : ………..

Place of the death : Home ☐ *Work* ☐ Outside ☐ Hopital ☐ Institution ☐ other ☐ *specify* :…………….

Describe (part, activity…) : ………………………………………………………………………………………

Exact position of the body : ………………………………………………………………………………………

If the death arose the night, specify circumstances: ……………………………………………………………

Presence of one person in the bedroom : Yes ☐ No ☐ DK (***don't know***)☐ ……………………… if yes, age : |__|__| years

Particular surveillance (monitoring, person…) : Yes ☐ No ☐ DK ☐

Use a "safe pillow": Yes ☐ No ☐ DK ☐

The patient lived: In family ☐ maritally ☐ in institution ☐ only ☐ in family and institution ☐

Event(s) during the last 24 hours: ____

____

CAUSE OF THE DEATH

Primary cause report :

SUDEP ☐ Accident ☐ downfall ☐ Drowning ☐ SE ☐ Suicide ☐ Other ☐ Specify :……………

Secondary cause ? ……………………………………………………………………………………………

Is it about an accident (drowning, AVP)? Yes ☐ No ☐ DK ☐ Specify : …………………………………..

***Is this accident* the consequence of a seizure ?** Yes ☐ No ☐ DK ☐

Did the death arise further to one seizure ? Yes ☐ No ☐ DN ☐

Is it probably an unexplained sudden death (SUDEP)? Yes ☐ No ☐ DK ☐

Is it probably a suicide? Yes ☐ No ☐ DK ☐ Specify : …………………………………………

Realized autopsy? Yes ☐ No ☐ DK ☐, if yes : Scientific autopsy ☐ or forensic ☐

Place (établishment, service) : ……………………………………

Results in wait : Yes ☐ No ☐ DK ☐ If no, Results :……………………………………………………

If no, reason : No ask ☐ Refuse ☐ Other ☐ specify : …………………

EPILEPSY

Age at onset of epilepsy : |__|__| years ou |__|__| months

Syndrome : idiopathic ☐ symptomatic ☐ cryptogenic ☐ DK ☐ Other ☐ Specify :…….

If lesional epilepsy, etiology : ………………………………………………………………

Type of crises : Partial ☐ Generalized ☐ Secondary generalized ☐ Unclassified ☐

If partial, type : ………………………………………………………………. Localization : ……………………………..

If Généralized, type : ……………………………Epileptic Syndrome :………………………………………

To return in the center coordination for the intention of ***Dr M-C Picot***
by letters : DIM - Unité Recherche Clinique, Hôpital La Colombière,
Pavillon 1 (ex SUPA), 39 avenue Charles Flahault, 34 295 Montpellier Cedex 5
or by Fax : **04 67 33 58 27** *(Version n°4 of 17/04/2013)*

Response treatment : Drug-Resistant ☐ Drug-Sensitive ☐ Relapse on treatment ☐ Insufficient backward ☐

Number of generalized seizures (or généralized secondary) during the last 3 months : |__|__|__| / months

Number of partial seizures during the last 3 months : |__|__|__| / months

Usual times of the seizures : Rather the night ☐ Rather the day ☐ both ☐ DK ☐

Was there a diagnostic workup of the epilepsy (EEG, MRI)? Yes ☐ No ☐

If yes, établishement : …………………………… years : |__|__|__|__| Neurologist : …………………..

Was there an assessment of operability of the epilepsy? Realized ☐ Not realized ☐ Not indicate ☐

If yes, établishment : …………………………… years : |__|__|__|__| Neurologiste : …………………..

Epilepsy surgery : Realized ☐ Not realized ☐

Current treatment at the time of the death: Yes ☐ No ☐, *If yes, list* ***ALL DRUGS*** *including psychotropic, oral contraceptives…*

Trade name + dosage	Posology	Generic medicine?	If generic medicine, laboratory
1……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….
2……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….
3……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….
4……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….
5……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….
6……………………………	…………….	Yes ☐ No ☐ DK ☐	…………….

Was there a recent change during the last 3 months of treatment and/or posology? Yes ☐ No ☐ , If yes, specify date and change : ………………………………………………

Taking of an oral contraception ? Yes ☐ No ☐ If yes specify : ……………………

Observance of treatment (over the last month): Good ☐ Average ☐ Bad ☐ DK ☐

Was the treatment correctly taken during the last 24 hours ? Yes ☐ No ☐ DK ☐

PAST HISTORY

Family history :

Cardiac Yes ☐ No ☐ DK ☐ If yes, specify (TdR, Card insuff…) :…………

Sudden death : Yes ☐ No ☐ DK ☐, link of parently : …………………………………………………

Others contributory histories (sleep apnes, patho. neurological, psychiatric) : ……………………

Personal histories :

Cardiac : Yes ☐ No ☐ DK ☐ If yes, specify (TdR, Card insuff, ECG anomaly) :…………………

Mental retardation : Yes ☐ No ☐ DK ☐, If yes, Light ☐ Moderate ☐ Severe ☐

Depressive disorders : Yes ☐ No ☐ DK ☐,

Anxious disorders : Yes ☐ No ☐ DK ☐

Sleep disorders : Yes ☐ No ☐ DK ☐, If yes, specify (sleep apnea…) :……………………

Alcohol consumption :

Occasional ☐ Moderate (≤ 2 consu./d) ☐ Excessive ☐ Dependence ☐ No ☐ DK ☐

Smoking : Occasional ☐ ≤ 10 cig/d ☐ Big smoker ☐ Old smoker ☐ No smoker ☐ DK ☐

Drugs consumption : Occasional ☐ Dependence ☐ No ☐ DK ☐

Other contributory consumptions or uses : ……………………………………………………………………

Date of the last consultation with a neurologist : |__|__| |__|__| |__|__|__|__|

INFORMATION CONCERNING YOU

Name First name : City of exercice :

@ : **(or stamp of the practitioner)**

☎ :

☐ **I informed the patient familly of existence of the network (Objective, database collection…)**

NEUROLOGIST PATIENT

Doctor : Etablishment : Service :

@ : ☎ : **Date :** |__|__| |__|__| |__|__|__|__| **Signature of the doctor:**

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