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SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

Valley Specialty Center
751 South Bascom Avenue
San Jose, CA 95128
Tel: 408-885-5000
scvmc.org

Neurology Referral Guidelines

Neurology Clinic Location:	Valley Specialty Center 1st floor 751 S. Bascom Ave.
Neurology Clinic Phone:	(408) 793-2458
Neurology Clinic Fax:	(408) 885-3017

This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.

E-CONSULT DISCLAIMER:

E-consults are based on the clinical data available to the reviewing provider, and are furnished without benefit of a comprehensive evaluation or physical examination. All advice and recommendations must be interpreted in light of any clinical issues, or changes in patient status, not available to the reviewing provider. The ongoing management of clinical problems addressed by the e-consult is the responsibility of the referring provider. If you have further questions or would like clarifications regarding e-consult advice, please contact the reviewing provider. If needed, the patient will be scheduled for an in-office consultation.

All URGENT consultations require provider-to-provider communication. If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.

Table of Contents

CEREBROVASCULAR DISEASE "STROKE"

1. **Background**
    a. We have found that most patients with recent stroke or TIA don't need to be seen in neurology clinic, as in almost all cases, the necessary evaluation is completed during the hospital stay.

2. **Pre-referral evaluation and treatment**
    a. For ischemic stroke:
        i. It is prudent to review the discharge summary and confirm that imaging of the cervical carotid arteries was performed, unless the infarct was in the posterior circulation.
            1. If you have any questions about those results, please e-consult us.
        ii. The 2019 Stroke Guidelines do not endorse routine use of echocardiography, or post-discharge monitoring for atrial fibrillation. Need for cardiac monitoring is determined by specific type of stroke, risk factors and age.
        iii. If a patient was discharged on dual anti-platelet therapy for stroke prevention, she should be switched to a single anti-platelet agent after 3 months.
            1. Unless the patient has a history of atrial fibrillation, cardiac thrombus, or documented hypercoagulable state, standard treatment consists of a single anti-platelet agent.
        iv. Treatment of lipids, blood pressure, and diabetes should conform to standard published guidelines.
    b. For hemorrhagic stroke:
        i. Some patients will require follow-up imaging.
        ii. Please e-consult us for any questions.
        iii. If the patient was admitted to an outside hospital, please obtain the discharge summary and any imaging reports, and forward to us along with the referral.

3. **Indications for referral**
    a. For any questions not addressed above, please e-consult us.

4. **Please include these with your referrals**
    a. Imaging reports of any prior cervical carotid artery evaluation.
    b. All prior discharge summary information and imaging reports.

DEMENTIA

1. **Background**
    a. Given the growing elderly population, the neurology clinic does not have the capacity to formally evaluate the vast majority of patients with dementia. The following guidelines will allow PCPs to evaluate and manage most patients.

2. **Pre-referral evaluation and treatment**
    a. Testing:
        i. If you feel the patient has objective memory deficits, then proceed with the standard work up:
            1. Head CT or MRI Brain
            2. Serum Vitamin B12
            3. TSH
            4. Syphilis serology studies (if history suggests appropriate risk factors)
        ii. Screen for depression and treat as appropriate
        iii. If you are not sure if patient meets criteria for a diagnosis of dementia, as opposed to mild cognitive impairment, that's ok. You can wait and see how things evolve over time. The fundamental criterion for the diagnosis of dementia is cognitive impairment sufficient to cause a change in social functioning or lifestyle (eg, job loss, unable to do grocery shopping, unable to avoid getting lost).
    b. Management:
        i. Treatment
            1. Although there are medications approved for dementia, our experience over the years has been universally disappointing. Rarely do families identify any significant improvement with donepezil/Aricept or memantine/Namenda. If the family feels strongly to try something, you can try donepezil/Aricept first and subsequently memantine/Namenda.
            2. Treat depression, if present.
        ii. Reporting
            1. Patients with moderate to severe dementia should be reported to DMV via Confidential Morbidity Report and should not be driving.
                a. If there is uncertainty, it is best to file the report. At your discretion, you may choose to recommend a behind-the-wheel driving test on that form, instead of making a unilateral recommendation to revoke driving privileges.
        iii. Special cases
            1. US Citizenship:

a. If a patient is trying to obtain US citizenship and is asking for documentation that cognitive impairment prevents them from passing the US citizenship exam, we recommend the following approach:
    i. If you feel that the patient is clearly demented, then you can do a MMSE or MOCA and complete the necessary form using your testing results for documentation.
    ii. If you feel that the cognitive impairment is ambiguous or assessment is complicated by possible depression or poor effort, you can refer to neuropsychology for a more comprehensive assessment.

c. **Comments regarding patients under age 70:**
    i. We have found that the majority of patients under 70 and the vast majority of patients under 60 with memory complaints do not have dementia. In most cases, they describe instances of forgetfulness or inattention that they consider out of the ordinary.
        1. One can still follow the guidelines above, but it is especially important to provide reassurance, when appropriate, that the patient does not have dementia. Often the anxiety about losing one's memory leads to hypervigilance and performance anxiety, leading to further impairment of attention and memory. In this age group, other common and important factors adversely affecting memory are: depression, anxiety, acute or chronic stress of any sort (but especially health-related, job-related, financial and family stress), polypharmacy, drug or alcohol abuse, chronic pain, chronic severe medical conditions and poor or insufficient sleep, including sleep apnea syndrome.

3. Indications for Referral

a. Patients with co-existing Parkinsonism, ataxia, or other disorders of motor function
b. Rapidly progressive dementia
c. For any questions not addressed above, please e-consult us.

4. Please include the following with your referral

a. Results of pre-referral testing

MIGRAINE and other headaches

1. **Background**
    a. The diagnosis of migraine headache can be safely made in the vast majority of patients with unilateral or bilateral headache that is severe enough to interfere with daily activities, and is associated with one or more additional features: nausea or vomiting; photophobia or phonophobia; relief with rest in a dark room; or typical visual or sensory aura. For chronic, non-specific headaches, one is often left with nothing to offer other than migraine treatment, once other more serious or specific causes have been ruled out.

2. **Pre-referral evaluation and treatment**
    a. Emergency Red Flags: (need to be addressed immediately, send patient to ED)
    i. Thunderclap headache: Onset of severe headache that is sudden (seconds to 1 minute from onset to peak intensity) should be sent to an emergency department with urgent computerized tomography (CT) capability for immediate investigation to exclude subarachnoid hemorrhage. If subarachnoid hemorrhage is not present on head CT scanning, other investigations (e.g., lumbar puncture) may be necessary.
    ii. Headache with fever and neck stiffness (meningismus): Patients with suspected bacterial meningitis should be sent immediately to an emergency department with urgent CT and lumbar puncture capability for investigation and treatment. Antibiotic therapy should not be unduly delayed by these investigations.
    iii. Papilledema in a patient with altered level of consciousness and/or focal signs: Patients with papilledema and altered level of consciousness and/or focal neurological signs may have a space-occupying lesion and may be at risk for incipient transtentorial herniation. They should be sent immediately to an emergency department with neuroimaging capability and specialist resources for investigation and treatment.
    iv. Acute angle-closure glaucoma: Patients with head pain and signs and symptoms of acute angle-closure glaucoma (non-reactive mid-dilated pupil, acutely inflamed eye, and visual disturbance with pain and nausea) should be sent immediately for assessment by an ophthalmologist or to an emergency department with the capability to measure intraocular pressure and initiate treatment.
    b. If no emergency red flags and normal neurological exam**:**
        i. Encourage healthy lifestyle, including adequate exercise and non-pharmacologic approaches to stress reduction

ii. Establish realistic expectations (eg, “there is no cure for migraine”, “not everyone responds to medication”) and provide reassurance
iii. Prescribe abortive treatment, as appropriate, (see below)
iv. Prescribe preventative medication, as appropriate, (see below)
v. For patients with chronic headaches and a history of fragmented sleep or symptoms of sleep apnea (frequent nocturia or nighttime awakenings and daytime drowsiness), evaluate for sleep apnea syndrome.

c. Testing
   i. For new onset headache without migraine features, the following should be considered based on clinical presentation:
      1. CT scan or MRI to rule out mass lesion;
      2. ESR for suspected temporal arteritis;
      3. LP for suspected infection; and
      4. Check for papilledema for suspected idiopathic intracranial hypertension (referral to optometrist or ophthalmologist)

d. Treatment

   i. **Abortive treatment: Suggested stepwise approach**
      1. NSAID (naproxen, ibuprofen, Excedrin Migraine)
      2. Triptan (sumatriptan, others)
      3. NSAID + Triptan
      4. If nausea and vomiting are problematic, use a standard anti-emetic, and consider a sublingual or intranasal formulation of a triptan.
      5. ***Note:*** If a drug from one class fails, it may be reasonable to try a 2nd or 3rd from that class, but the chance of success declines with each successive trial. Abortive medications are best restricted to 2-3 days of use per week, to avoid medication overuse headache. Exceptions to this recommendation can be considered for cases when results are good even with more frequent use of the abortive agent.

   ii. **Preventative oral treatment: Suggested medications and general approach**
      1. Riboflavin: 400 mg per day (benefit may be delayed by 4-6 weeks)
      2. Tricyclic antidepressant (eg, amitriptyline/Elavil, 10 – 75 mg qHS)
         a. BE ADVISED: Concurrent use of SUMATRIPTAN and TRICYCLIC

ANTIDEPRESSANTS may rarely result in increased risk of serotonin syndrome.

3. propranolol/Inderal (20 – 80 mg bid) or other beta blocker
4. topiramate/Topamax (25 – 100 mg bid) REQUIRES USE OF RELIABLE BIRTH CONTROL IN WOMEN OF CHILDBEARING AGE
5. valproic acid/Depakote (250 – 750mg bid) AVOID IN WOMEN OF CHILDBEARING AGE
6. **Notes:**
    a. Preventative treatment can be attempted whenever a patient has frequent migraines(More than two days out of a week) that are disabling despite attempts at abortive treatments. However, it is important to establish realistic expectations early on, because a meaningful benefit may occur in just a minority of patients with any given medication, depending on how "benefit" is defined. It is worth emphasizing non-pharmacologic approaches such as daily exercise, relaxation and stress-reduction practices, healthy diet, and good sleep hygiene.
    b. As a rule, preventative drugs should be started at a low dose and gradually increased as tolerated and as needed until desired results are achieved or the medication is deemed a failure. Treatment should be maintained at maximum tolerated dose for 3 weeks before final judgment is passed as to efficacy. See Up-To-Date or other reliable source for specific dosing recommendations.

iii. **Preventative injectable treatment: Suggested medications and general approach**

a. Botox is FDA-approved for adults with chronic migraines, with headache frequency of 15 or more days a month after failure of multiple trials of preventative medication, per above recommendations.
b. Monoclonal Antibodies to Calcitonin Gene-Related Peptide/Receptor (Ajovy, Aimovig, Emgality, etc): Can be prescribed after prior authorization as monthly injections for

patients(age 18-65) with history of migraines for duration of more than 12 months and 4-14 migraine days per month during 3-month prior to screening.

3. Indications for referral

a. For any questions not addressed above, please e-consult us.
b. Following atypical features need investigation within days:
    1. Patients with new onset headache or a major change in headache pattern and a systemic illness (cancer, human immunodeficiency virus [HIV], etc.), obtain head imaging.
    2. New onset headache in patients over 50 years of age with other symptoms suggestive of temporal arteritis: Patients over 50 years of age with new onset headache and other symptoms of temporal arteritis (jaw claudication, transient visual loss, etc.) should receive urgent investigation (erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], and if indicated, temporal artery biopsy), and may require specialist consultation and early systemic corticosteroid treatment.
    3. Papilledema in an alert patient without focal neurological signs: Patients with papilledema, a normal level of consciousness, and no focal neurological signs may have benign intracranial hypertension (pseudotumour cerebri). They should have urgent specialist referral and will need urgent neuroimaging. An intracranial space-occupying lesion should be ruled out prior to lumbar puncture to measure cerebrospinal fluid (CSF) pressure. Further investigation may be required as the differential diagnosis would include cerebral venous sinus thrombosis.
    4. Elderly patient with new headache and subacute cognitive change: Elderly patients with a new headache and a recent subacute (days to weeks) decline in cognition may have a subacute or chronic subdural hematoma. A history of head injury is not always present. They require urgent specialist referral and/or brain CT imaging.
    5. Neuropathic headache (occipital neuralgia, trigeminal neuralgia)

c. Patients with history of refractory migraines (documented failure of trial of at least 3 preventive medications) with headache frequency more than 4 days per month during > 3-month prior to screening. These patients can be considered for treatment with Botox versus Monoclonal Antibodies to Calcitonin Gene-Related Peptide/Receptor (Ajovy, Aimovig, Emgality, etc): Prior to consideration of the injectable medications, it is required to 1) document adequate trial of >2 months with treatment failure or inadequate response to 3 preventive agents for migraines listed

above., 2) If prescribed triptan or ergotamine products, patient is using less than 10 days per month 3) Patient does not have history of cluster headache or hemiplegic migraine, 4) Patient does not have cardiac comorbidities [eg uncontrolled hypertension, history of myocardial infarction (MI), stroke, transient ischemic attack (TIA), unstable angina, coronary artery bypass surgery, 5) Patient does not have abnormal blood vessels of the brain (eg arteriovenous malformation, aneurysm, arterial dissection, reversible cerebral vasoconstriction) , 6) Patient does not have history of thrombotic event , 7) Patient does not have alanine transaminase (ALT) greater than 1.5 times upper limit of normal or known liver disease, 8) Patient does not have abnormal blood vessels of the brain (eg arteriovenous malformation, aneurysm, arterial dissection, reversible cerebral vasoconstriction

   d. Read more at: https://www.guidelinecentral.com/summaries/guideline-for-primary-care-management-of-headache-in-adults

4. **Please include with your referral**
   a. Results of pre-referral testing

RADICULOPATHY

1. **Background**
   a. We recommend the same standard approach that most consensus guidelines recommend, as outlined below.

2. **Pre-referral evaluation and treatment**
   a. Testing
      i. If you find good clinical evidence for radiculopathy, with no improvement with 4-6 weeks of analgesics and PT, and the patient is potentially a good surgery candidate, we recommend getting an MRI directly.
         1. Of course, the presence of any “red flags” suggesting spinal infection, fracture, or malignancy is an indication for more urgent or emergent imaging.
      ii. We discourage the use of EMG as a screening test for radiculopathy due to its low sensitivity. EMG and nerve conduction studies have a low sensitivity because motor fiber involvement is often minimal. Subtle abnormalities are easy to miss, and lesions of sensory fibers at the root level will not show up on these tests.
         1. In short, EMG data rarely adds to the clinical decision-making in these cases.
            a. A normal EMG does not rule out radiculopathy.

b. Conversely, an abnormal EMG does not, per se, necessitate an MRI and surgical intervention.

3. **Indications for referral**
    a. For any questions not addressed above, please e-consult us.

4. **Please include with your referral**
    a. Results of pre-referral testing

VERTIGO

1. **Background**
    a. Vertigo is usually a spinning sensation, but can also be any illusion of movement (eg, tilting or falling to one side). The differential diagnosis can usually be narrowed down substantially based on the temporal characteristics and associated clinical features, as below.

        i. Differential includes:
            1. **Acute, new onset, severe and sustained vertigo (usually lasting a few days):**
                a. In the absence of acute hearing changes, the differential diagnosis is essentially limited to an acute lesion (usually infarct) of the brainstem or cerebellum vs vestibular neuronitis.
            2. **Recurrent episodes of vertigo:**
                a. In the absence of other brainstem symptoms or signs (eg, diplopia, dysphagia, dysarthria, or ataxia), central causes of vertigo can be excluded (with the possible exception of migraine (see below).
                    i. TIAs, multiple sclerosis, or structural lesions of the brain do not cause recurrent episodes of isolated vertigo, and brain imaging is generally not useful.
                b. The differential diagnosis includes peripheral causes, such as Benign Paroxysmal Positional Vertigo (BPPV), Meniere's disease, and idiopathic recurrent vestibulopathy (a diagnosis of exclusion).
                    i. We encourage PCPs to become familiar with the diagnosis and treatment of BPPV.

3. **Migrainous vertigo:**
    a. If recurrent episodes of vertigo last 15 to 30 minutes, or possibly longer, and are consistently associated with an episodic headache with migrainous features, then the diagnosis is fairly straightforward.
    b. If episodes of vertigo do not have the above features, then the diagnosis of migrainous vertigo is highly doubtful.
4. **Vestibular schwannoma:**
    a. The vestibular symptoms of vestibular schwannoma can be chronic, subtle, and fluctuating. Frank vertigo is uncommon.
    b. Tinnitus and hearing loss are common, but a minority of patients may not be aware of the gradual onset of unilateral hearing loss.
    c. Only 5% of patients will have normal audiometry, therefore it would be the first test to address this concern.

2. Pre-referral evaluation and treatment

a. Management:

i. **Summary of Recommendations**

1. **If acute stroke is a possibility, refer to ED.** If you are not comfortable ruling out stroke based on clinical features and risk factor profile, then referral to the ED is recommended.
2. **Consider alternate diagnoses**
    a. Acute vestibular neuronitis
        i. Can be managed conservatively with meclizine and bed rest.
        ii. If hearing changes are present, consult ENT.
    b. BPPV
        i. ENT clinic has the capacity to evaluate and treat BPPV
        ii. Otherwise, order audiometry and refer to ENT and vestibular rehab.
    c. Migraine
        i. Treatment is based on the standard approach to migraine prophylaxis in general, but response to treatment is variable, as it always is in the case of migraine.

ii. Empiric trials of migraine prevention medication can be offered, but a good response is unlikely.

d. Vestibular schwannoma

i. The best initial screening test is audiometry.

3. **When in doubt, order audiometry and consult ENT**

3. Indications for referral

a. For any questions not addressed above, please e-consult us.

4. Please include with your referral

a. Results of pre-referral testing

DIZZINESS AND IMPAIRED BALANCE

1. Background

a) As with vertigo, the differential diagnosis can usually be narrowed down substantially based on the temporal characteristics and associated clinical features, as below:

i. If the patient endorses episodic light-headedness, then consider pre-syncope, and evaluate accordingly (ie, consider the differential diagnosis of syncope)

ii. If the patient does not endorse light-headedness or vertigo but only vague dizziness or impaired balance, and the episodes are relatively brief, with remissions that are clearly longer than the episodes themselves, follow the recommendations for recurrent episodic vertigo, as above.

iii. For vague dizziness or disturbance of balance that is present most of the time, a brief focused neurologic exam is very useful. Important causes to be considered at this point are chronic peripheral vestibular dysfunction, cerebellar degeneration, and ataxic sensory polyneuropathy. The neurologic exam should include a gross assessment of eye movements and hearing, gait, and tandem gait testing, and the Romberg test.

1. When testing gait, one is looking for consistent abnormalities suggesting ataxia, or other overt gait disorder.
2. With regard to tandem gait: an occasional falter, if the patient is able to steady oneself, is usually not significant.
3. If the Romberg test is positive (slight self-correcting swaying is usually not significant), one should also look for significant deficits in proprioception and other signs of peripheral neuropathy.

4. If the above aspects of the neurologic exam are normal, cerebellar disorders and polyneuropathy can be ruled out. BPPV should be re-considered at this point, because some patients may be describing the vague sense of dizziness they feel in between intense attacks of vertigo.
    a. Inquire about brief, intense episodes of "dizziness" associated with head movement.
    b. As a final step, consider audiometry and referral to ENT.

iv. In the end, many, if not most, cases of chronic, non-specific dizziness will defy definitive diagnosis.
    1. Proposed terms for such cases include: "persistent postural perceptual dizziness" (when symptoms are present only when standing), and "psychophysical dizziness".
    2. Physical therapy with "vestibular rehabilitation" may be helpful in some cases.

2. Pre-referral evaluation and treatment

Management:

i. **Summary of Recommendations:**
    1. Consider pre-syncope
    2. If episodes are brief, consider recurrent episodic vertigo
    3. Perform focused neurologic exam
    4. If focused neurologic exam is abnormal, consult neurology (based on exam findings, an EMG or MRI may be indicated prior to neurology clinic visit)
    5. If focused neurologic exam is normal, consider BPPV (with inter-attack residual dizziness), audiometry, and referral to ENT
    6. If no definitive diagnosis is possible, consider referral to PT

3. Indications for referral

a. For abnormal findings on focused neurological exam, or any questions not addressed above, please e-consult us.

4. Please include with your referral

Results of pre-referral testing

Post concussive syndrome

1. **Background**
   a. Post concussion syndrome may result from brain injury or from trauma involving head and neck structures. These include headache, dizziness (including vertigo and nonspecific dizziness), neuropsychiatric symptoms, and cognitive impairment. These typically develop in the first days after mild TBI and generally resolve within a few weeks to a few months.
   b. We recommend the same standard approach that most consensus guidelines recommend, as outlined below.

2. **Pre-referral evaluation and treatment**

a) Management:
   i) **Summary of Recommendations:**

   There is no specific treatment for post-concussion syndrome. The types of symptoms and their frequency are different for everyone:

   a. Headaches: Medications commonly used for migraines or tension-type headaches, including some antidepressants, antihypertensive agents and anti-epileptic agents, appear to be effective when these types of headaches are associated with post-concussion syndrome. Keep in mind that the overuse of over-the-counter and prescription pain relievers may contribute to persistent post-concussion headaches.

   b. Memory and thinking problems: No medications are currently recommended specifically for the treatment of cognitive problems after mild traumatic brain injury. Time may be the best therapy for post-concussion syndrome. Certain forms of cognitive therapy may be helpful, including focused rehabilitation that provides training in the specific areas that patient need to strengthen. Some people may need occupational or speech therapy. Stress can increase intensity of cognitive symptoms and learning stress management strategies can be helpful to decrease cognitive symptoms. Relaxation therapy also may help.

   c. Depression and anxiety: The symptoms of post-concussion syndrome often improve after the affected person learns that there is a cause for his or her symptoms and that they will likely improve with time. Education about the disorder can ease a person's fears and help provide peace of mind.

3. **Indications for referral**

a. For abnormal findings on focused neurological exam, or any questions not addressed above, please e-consult us.

Driver Safety for Lapses of Consciousness Disorders

1. Background

a) Disorders characterized by lapses of consciousness result from many medical conditions. Epilepsy(seizure disorder) is the most common disorder seen by neurology department.
b) Sleep disorders and syncope can also manifest themselves as a loss of awareness or loss of consciousness.
c) Every state regulates driver's license eligibility of persons with certain medical conditions. The most common requirement for people with epilepsy is that they be seizure free for a specific period of time and submit a physician's evaluation of their ability to drive safely. Regulations governing lapses of consciousness disorders are contained in Article 2.4, Sections 110.01 and 110.02, of Title 13, California Code of Regulations.
d) Every physician and surgeon must immediately report to the local health officer individuals 14 years of age and older whom they have diagnosed as having "a disorder characterized by lapses of consciousness

a) Driver Medical Evaluation to release driver's license:

i. Form DS 326 is requested when medical information is needed to evaluate a driver's medical condition in relationship to safe driving. Primarily used by Driver Safety, this five-page document assists hearing officers to evaluate the physical and/or mental condition(s) of the driver and to determine what action, if any, to take with regard to the driving privilege.

ii. The first page of the Driver Medical Evaluation (DME) form requires the driver to complete a brief health history and to certify under penalty of perjury that the information is true and complete. The remainder of the form requires the driver's physician to provide information on the driver's diagnosis, treatment, and level of functional impairment, if any. Specific sections address lapses of consciousness, diabetes, dementia and cognitive impairments, as they pose a higher degree of potential traffic safety risk.
iii. This form can be found at following link:

iv. **https://www.dmv.ca.gov/portal/wcm/connect/f92586ac-be7a-456b-af31-b35acc029982/ds326.pdf?MOD=AJPERES&CVID=**

b) **Who can fill the DMV paperwork:** Given the large volume of requested paper work at the neurology clinics we are urging the primary care doctors to not refer patients solely for filling out the DMV paper works, please find below the guidelines

i. We strongly encourage the primary care physicians to fill DMV paper work for patients who remain seizure free without further loss of consciousness for at least 3 months.
ii. If Patient has underlying medical condition causing recurrent lapses of awareness it is important to treat underlying cause prior to releasing their driver's license. This include but not limited to patients requiring Pacemaker for heart block or seizure medications with therapeutic blood levels for epilepsy.
iii. Regarding loss of consciousness due to seizures, if it is one time seizure and the neurologist after seeing the patient determines no further follow up required and no need for AEds then also the DMV paper work can be filled by Primary care provider. Please inform us if recurrent seizures.

Revisions:

- May 2017, formatting and content
- Oct 2017, formatting
- March 2018, content
- April 2020, formatting and content