Ketogenic Diet Clinic: New Patient Form

Your child has been referred to the ketogenic diet clinic at Children's Healthcare of Atlanta. Please complete this form and return to us using one of the following ways:

- By Mail: Children's Healthcare of Atlanta, EEG Department/Ketogenic Diet Clinic, 1405 Clifton Road NE, Atlanta, GA 30322
- By Email: ketoclinic@choa.org
- By Fax: 404-785-3876

Background Information		
Child's Name:		
Parent/Caregiver Name(s):		
Date of Birth:		Sex: ☐ Male ☐ Female
Address:		
City:	State:	Telephone Number:
Email Address:		
How do you prefer to be contacted? ☐ Telephone ☐ Email ☐ Mail ☐ No preference		
Pediatrician:		Gastroenterologist (GI Doctor):
Have you heard of the ketogenic diet before? ☐ Yes ☐ No		
What are your goals or expectations for starting the ketogenic diet for your child?		
What concerns do you have about starting your child on a ketogenic diet?		
Does your child have any allergies: Medication? ☐ Yes ☐ No List: Food? ☐ Yes ☐ No List:		
Does your child have any cultural or religious dietary restrictions? ☐ Yes ☐ No List:		
Have there been any recent changes in your child's weight? ☐ Yes ☐ No Explain:		

Medical History

Describe your child's seizures.

On average, how many seizures is your child having:

- Each day?
- Each week?
- Each month?

Does your family have a history of:

- Heart disease? ☐ Yes ☐ No
- Stroke? ☐ Yes ☐ No
- High Cholesterol or Lipids? ☐ Yes ☐ No
- Kidney Stones? ☐ Yes ☐ No
- Other? Please list.

What seizures medications has your child previously tried? Please list.

Does your child have:

- A hard time swallowing? ☐ Yes ☐ No ☐ Does not apply
- A hard time chewing? ☐ Yes ☐ No ☐ Does not apply
- Constipation? ☐ Yes ☐ No ☐ I'm not sure
- Loose stools? ☐ Yes ☐ No ☐ I'm not sure
- Reflux? ☐ Yes ☐ No ☐ I'm not sure
- A feeding tube? ☐ Yes ☐ No ☐ I'm not sure
- Difficulty taking pill/tablet medications? ☐ Yes ☐ No ☐ Does not apply
- A good appetite? ☐ Yes ☐ No ☐ Does not apply
- Any sensory issues related to food? ☐ Yes ☐ No ☐ Does not apply to my child ☐ I'm not sure

Does your child have any other medical conditions in addition to seizures? ☐ Yes ☐ No List:

Has your child had an EEG before? ☐ Yes ☐ No ☐ I'm not sure When:

Has your child had an MRI before? ☐ Yes ☐ No ☐ I'm not sure When:

Has your child had a swallow study test (OPMS, FEES) before? ☐ Yes ☐ No ☐ I'm not sure When:

Has your child had any genetic testing completed? ☐ Yes ☐ No ☐ I'm not sure

- Which test(s)?
- Where?
- When?

Medicines/Vitamins					
List the name of each medicine or vitamin supplement your child takes	**How much does your child take?**	**How often is it supposed to be taken?**	**How does your child take this medication?**	**Why does your child take this medication?**	**How often did your child take the medicine last week?**
Example: Prevacid	*15 mg*	*Once a day*	*By mouth*	*For Reflux*	☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Everyday
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Everyday
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					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Everyday

Does your child take a CBD/Low THC Oil product? ☐ Yes ☐ No

Nutrition History – Please complete the section(s) that reflect your child's current diet.	
Oral Food-based Diets	**Formula/Tube Feeding Diets**
How many: • Meals does your child have per day? • Snacks does your child have per day?	What is the name of the formula your child takes?
What are you child's favorite meals?	Does your child drink their formula? ☐ Yes ☐ No
	Does your child have a feeding tube? ☐ Yes ☐ No • If yes, what kind of tube? ☐ NG ☐ NJ ☐ GT ☐ GJ ☐ Other: • Does your child have a fundoplication? ☐ Yes ☐ No ☐ I'm not sure
What beverages does your child like to drink?	What is your child's feeding regimen? *(Example: 240 mL four times per day)*
Are there any foods your child does not like or will not eat? List.	Does your child get any additional water during the day? ☐ Yes ☐ No ☐ I'm not sure • How much? • How many times per day?
Does your child need their food to be in a special consistency? ☐ Yes ☐ No ☐ I'm not sure ☐ Pureed ☐ Mechanical Soft ☐ Chopped	Do you add anything to the formula (such as water, protein supplement, pedialyte, etc.)? ☐ Yes ☐ No List:
Does your child need liquids to be thickened? ☐ Yes ☐ No ☐ I'm not sure • If yes, what thickener do you use? • What consistency do you thicken liquids to? ☐ Honey ☐ Nectar ☐ Spoon/Pudding	Who supplies your formula? ☐ Soft Touch Medical ☐ Coram ☐ Enteral Central ☐ Walgreens Infusion ☐ Adult & Pediatric Specialists ☐ Apria ☐ Lincare ☐ Sherwood Clinical ☐ WIC Program ☐ Other:

For Office Use Only:

Reviewed by: ☐ Nurse _____ ☐ Nutritionist _____ ☐ Physician _____

Decision: ☐ Candidate ☐ Not a Candidate

Reason: _____

Plan: _____

Provider Signature: _____

Date: _____