ETV emergency information

Fill out this form to keep all your information in one place. Just write N/A where something doesn't apply.

Name: _____ Date of birth: ___/___/___

Condition: hydrocephalus caused by _____

NHS number: _____

Neurosurgical Centre: _____

Consultant: _____ Direct line: _____

Clinical Nurse Specialist: _____

Email: _____ Direct line: _____

Type of ETV (most recent): ☐ Endoscopic Third Ventriculostomy (ETV) ☐ Endoscopic Third Ventriculostomy and Choroid Plexus Coagulation (ETV-CPC)

	Date:	Where:
Most recent ETV	___/___/___	_____
Reservoir inserted ☐	Reservoir type:	_____
First ETV (if different)	___/___/___	_____
Other revisions:	_____	
Last MRI	___/___/___	_____
Last CT scan	___/___/___	_____

CT scans to date: _____

Other medical/surgical history: (e.g. shunt surgery, slit ventricles, infections, other conditions)

_____

Allergies: _____

Vaccination status: _____

Local Paediatrician: _____ Direct line: _____

GP practice: _____

GP name: _____ Direct line: _____