1 Patient & Encounter Information

Name:	Ethan C. Morrison
DOB / Age:	February 18, 2016 / 9 years, 2 months
Sex:	Male
MRN:	MRN-8834721
Primary Language:	English
Insurance / Payer:	Medicaid / NC Health Choice
Date of Visit:	April 27, 2025
Location of Service:	UNC Children's Pediatric Neurology Clinic, Chapel Hill, NC
Visit Type:	New Consultation
Referring Provider:	Dr. Patricia Simmons, MD (Pediatrician, Durham, NC)
Pediatric Neurologist:	Dr. Caroline E. Webb, MD — Pediatric Neurology
Accompanied by (parent / guardian):	Mother: Tanya Morrison (primary caregiver, present); Father: David Morrison (present via FaceTime)

2 Chief Complaint

Primary neurological concern:	New-onset focal seizures — episodes of staring and right hand automatisms, first witnessed at school 6 weeks ago
Duration:	Seizure episodes beginning 6 weeks ago. Three witnessed episodes and multiple suspected episodes reported by teacher.

3 History of Present Illness

GENERAL

Onset / duration / frequency / progression:	Onset 6 weeks ago. Initial episode in classroom — staring, unresponsive for 30–60 seconds, followed by repetitive hand movements. Now occurring 2–3 times per week per teacher report. Duration 45–90 seconds. Post-ictal fatigue lasting 5–10 minutes. No generalized tonic-clonic seizures witnessed.
Context / triggers:	No clear precipitating factors identified. Episodes occur at school during quiet activities. No fever, sleep deprivation, or specific triggers identified. Teacher initially thought child was daydreaming.

SYMPTOM CHARACTERIZATION

Seizures (type, triggers, duration, postictal state):	Focal aware/impaired awareness seizures — staring with cessation of activity, right-hand automatisms (picking, rubbing motions), oral automatisms (lip

	smacking). Duration 45–90 seconds. Post-ictal: fatigue and brief confusion lasting 5–10 minutes. No generalization witnessed. No aura reported by child.
Abnormal movements (tremor, tics, chorea, dystonia):	No tremor, dystonia, or chorea. Mild facial tics (eye blinking, nose twitching) — present for 2 years, consistent with transient tic disorder. Not new.
Weakness / tone abnormalities:	No focal weakness. Normal tone throughout. No history of hemiparesis or hypotonia.
Sensory changes:	No sensory complaints. No paresthesias. Child unable to recall aura but describes 'funny feeling in stomach' before some episodes.
Headaches / migraines:	Headaches reported 1–2 times per week — bifrontal, mild, resolving with rest or acetaminophen. No family history of migraine. May be stress-related or post-ictal.
Behavioral / cognitive concerns:	ADHD diagnosed at age 7 — on mixed amphetamine salts 10mg daily. Teacher reports worsening attention over past 2 months, possibly related to seizure activity.

ASSOCIATED SYMPTOMS & IMPACT

Sleep / feeding / swallowing / coordination:	Sleep: 9–10 hours nightly, no parasomnia, no snoring. Feeding: good appetite, no swallowing difficulties. Coordination: age-appropriate per parental report. No regression in motor skills.
Functional impact (school, ADLs, play):	School performance declining — grades dropped from B to C/D since seizure onset. Teacher has implemented accommodations. Missing recess due to post-ictal fatigue. Peers noticing episodes.
Caregiver input (regression, behavior, concerns):	Mother very concerned — witnessed one episode at home last week. Child becomes quiet and 'stares through her.' Reports no regression. Child embarrassed about episodes at school. Parents fear epilepsy diagnosis will affect school placement.

PRIOR WORKUP & TREATMENTS

Prior workup (EEG, imaging, labs, genetic testing):	EEG ordered by pediatrician — performed at Duke Children's 2 weeks ago. Report pending at time of that visit. No prior imaging. Basic metabolic panel and CBC at referring pediatrician: normal.
Prior treatments (meds, PT/OT, speech, behavioral, school):	ADHD: mixed amphetamine salts (Adderall XR) 10mg daily — for 2 years, moderate benefit. No prior AED therapy. School accommodations: extended time, preferential seating.

4 Prenatal & Birth History

Maternal conditions / exposures:

	GDM during pregnancy — diet-controlled. No medications during pregnancy. Non-smoker. No alcohol or drug use. No teratogen exposure. TORCH screen negative.
Gestational age:	39 weeks, 2 days — full-term
Delivery type:	Normal spontaneous vaginal delivery (NSVD)
Birth weight / Apgar scores:	7 lbs 4 oz (3.3 kg). Apgar scores: 8 at 1 minute, 9 at 5 minutes.
Neonatal complications (NICU, seizures):	None — no NICU admission, no neonatal seizures, no hypoxia. Discharged home at 48 hours.

5 Developmental History

Gross motor:	Normal milestones — sat at 6 months, walked at 12 months. No regression. Currently rides bike without training wheels.
Fine motor:	Within normal limits — adequate for age. Writing legible. No regression.
Speech / language:	Age-appropriate. First words at 12 months, phrases at 18 months. No speech therapy history. Articulation clear.
Social / behavioral:	Social and interactive with peers. ADHD affects attention in structured settings. No autism spectrum concerns. Has friends at school.
Regression:	No developmental regression. However, school performance decline over past 6 weeks coincides with seizure onset.
School performance:	3rd grade, regular education with accommodations. Previously performed at grade level. Recent decline — grades dropped from B to C/D. Teacher requests updated neurological evaluation.

6 Past Medical & Surgical History

Neurological conditions:	None prior to current seizure onset. ADHD since age 7.
Other chronic illnesses:	Mild intermittent asthma — uses albuterol PRN (rarely). Seasonal allergic rhinitis — loratadine 10mg daily.
Surgeries (neuro / ortho):	Bilateral ear tubes (myringotomy) — age 3. No other surgeries.

7 Medications

Current medications:	1. Mixed amphetamine salts (Adderall XR) 10mg — every morning (ADHD) 2. Loratadine 10mg — daily (allergic rhinitis) 3. Albuterol MDI — PRN (asthma, rarely used)
Prior medications:	Methylphenidate 5mg — tried age 7, discontinued due to appetite suppression. Amoxicillin — multiple courses for otitis media (resolved with tubes).
Adherence / side effects:	

	Adderall XR — good adherence per mother. Side effects: mild appetite suppression at lunch. No mood changes. School nurse confirms daily administration.

8 Allergies

Drug allergies + reaction:	Amoxicillin — rash (maculopapular, mild, at age 4, resolved). Penicillin class avoided.
Other relevant allergies:	Tree pollen and dust mites — seasonal rhinitis. No food allergies. No latex allergy.

9 Family History

Mother (age 34): ADHD, anxiety — treated
Father (age 37): No neurological conditions
Maternal uncle (mother's brother, age 38): Childhood absence epilepsy — outgrew in adolescence, never on medications as adult
MGM (maternal grandmother): Migraine
No family history of febrile seizures, intellectual disability, or other epilepsy syndromes
Family history of childhood epilepsy on maternal side is significant

10 Social History

Household:	Lives with both parents in Durham, NC. Stable home environment. Two younger siblings (ages 5 and 3) — no neurological conditions.
School / daycare:	James Monroe Elementary School, Durham, NC. 3rd grade regular education with 504 plan for ADHD.
IEP / 504 plan:	Current 504 plan for ADHD — extended time on tests, preferential seating. IEP not in place. School has been notified of seizure activity.
Activities / screen time:	Soccer (recreational, weekends). Swimming lessons. Screen time approximately 2 hours per day (within AAP guidelines). No significant screen-time increase recently.

11 Review of Systems

Neurological ROS:	Focal seizures (as above), mild headaches, no syncope, no weakness, no numbness, no vision changes, facial tics (chronic, stable)
Behavioral / Psych:	ADHD (diagnosed, on treatment). Mild social anxiety around seizure episodes at school. No depression. PHQ-A: not applicable (age 9).
Sleep ROS:	9–10 hours nightly. No parasomnia. No snoring or witnessed apneas. No night terrors. No enuresis.
Other relevant systems:	

	Mild intermittent asthma (well-controlled). Seasonal allergic rhinitis (on loratadine). No cardiac symptoms. No abdominal complaints.

O Objective

12 VITALS & GROWTH

BP:	102/64 mmHg (right arm)	**RR:**	18 breaths/ minute	**SpO2:**	99% on room air
HR:	88 bpm, regular	**Temp:**	98.2°F (36.8°C)	**Height / Weight / HC:**	Height: 4'4" (132 cm) — 55th percentile | Weight: 68 lbs (30.8 kg) — 50th percentile | Head Circumference: 53 cm — 60th percentile

13 NEUROLOGICAL EXAMINATION

Mental status:	Alert, interactive, and cooperative. Age-appropriate vocabulary and abstract reasoning. Good eye contact. Attentive during exam with some distractibility consistent with ADHD.
Cranial nerves:	CN II: Visual acuity 20/25 bilateral (glasses worn). Visual fields full to confrontation. CN III/IV/VI: EOM intact, no nystagmus. CN VII: Facial symmetry intact. CN VIII: Hearing grossly intact. CN IX/X: Palate elevates symmetrically. CN XII: Tongue midline.
Motor:	Strength 5/5 all four extremities. No focal weakness. No drift on pronator drift testing.
Tone:	Normal tone throughout all four extremities. No spasticity, flaccidity, or rigidity.
Sensory:	Intact to light touch, pinprick, and proprioception bilaterally. Age-appropriate responses.
Reflexes:	DTRs 2+ and symmetric at biceps, triceps, brachioradialis, patellar, and Achilles. Plantar reflexes flexor bilaterally.
Coordination:	Finger-to-nose: accurate bilaterally. Rapid alternating hand movements: intact. Heel-to-shin: accurate. No intention tremor.
Gait:	Heel-to-toe walking intact. Normal tandem gait. Romberg negative. Running gait age-appropriate.

14 DIAGNOSTIC DATA REVIEWED

MRI / CT:	MRI Brain with and without contrast (ordered today, urgent) — pending. Prior CT head not performed. MRI preferred to avoid radiation.
EEG:	Outpatient routine EEG (Duke Children's, 2 weeks ago): Report reviewed — 'left temporal slowing with intermittent sharp waves in left temporal region (T3/T7). No electrographic seizures captured

	during 40-minute recording. Abnormal EEG, focal left temporal dysfunction.' Independent interpretation confirmed at today's visit.
Labs / metabolic:	CBC: WBC 6.8, Hgb 12.9, Plt 234 — normal. BMP: Na 138, K 3.9, Glucose 92, Cr 0.6 — normal. No metabolic abnormality. Glucose normal — hypoglycemia excluded. Lead level: 2 mcg/dL (normal).
Genetic testing:	Not yet performed. Pending — epilepsy gene panel to be ordered (consider SCN1A, SCN2A, KCNQ2, CDKL5, and childhood epilepsy panel) pending MRI and clinical picture.
Independent interpretation performed:	Yes — EEG from Duke Children's reviewed and independently interpreted by Dr. Webb at today's visit: left temporal focal sharp waves confirmed.

A Assessment

15 DIAGNOSES

Primary diagnosis:	New-onset focal epilepsy — focal aware and focal impaired awareness seizures with left temporal EEG correlate, suspected left temporal lobe epilepsy
ICD-10 Code:	G40.109 (Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus)
Secondary diagnoses:	ADHD, combined presentation (F90.2); Transient tic disorder (F95.0); Mild intermittent asthma (J45.20); Allergic rhinitis (J30.9)
Differential diagnoses:	1. Childhood absence epilepsy — less likely given focal EEG abnormality and post-ictal fatigue; 2. Focal cortical dysplasia — MRI will help exclude structural lesion; 3. Low-grade temporal lobe tumor — MRI ordered urgently; 4. Autoimmune encephalitis (anti-NMDA, LGI1) — less likely, no encephalopathic features; 5. ADHD inattention — partially explains school difficulties but seizures are separate
Severity / functional impact:	Moderate — seizures occurring 2–3 times per week, impacting school performance, causing social embarrassment, and post-ictal fatigue. No generalized seizures or status epilepticus. No injuries from episodes.

16 MEDICAL DECISION MAKING

Problems Addressed:	New-onset focal epilepsy — requiring AED initiation and MRI; ADHD medication review; school accommodation update
Data Reviewed:	EEG report (independently interpreted); CBC and BMP; referral notes from pediatrician; school correspondence
Risk Level (Low / Moderate / High):	Moderate — focal epilepsy with functional impact; low risk for SUDEP at this stage; ongoing seizure activity at school requires intervention

P Plan

17 MANAGEMENT

Medications plan:	INITIATE oxcarbazepine (Trileptal) 150mg BID (8 mg/kg/day) — first-line for focal epilepsy in children. Titrate to 300mg BID after 2 weeks if tolerated. Prescriptions written today with detailed

	instructions. Dispense with MedicAlert bracelet recommendation. Continue Adderall XR 10mg — no interaction with oxcarbazepine at current doses.
Therapies (PT / OT / Speech / Behavioral):	No PT, OT, or speech therapy indicated at this time. Behavioral therapy referral considered for school anxiety related to seizures — social worker contact initiated.
Diagnostics ordered:	1. MRI Brain with and without gadolinium (URGENT — within 1 week); 2. Extended 2-hour outpatient EEG with sleep (within 2 weeks); 3. Epilepsy gene panel (blood draw today — 35-gene childhood epilepsy panel); 4. Metabolic panel recheck in 4 weeks (sodium monitoring on oxcarbazepine — hyponatremia risk)
Referrals:	Pediatric neuropsychology — formal ADHD and cognitive assessment in context of new epilepsy. Ophthalmology — baseline visual fields (oxcarbazepine monitoring). Social work — school coordination and family support.
IEP / school coordination:	504 plan update requested — add seizure action plan, seizure first aid training for teachers, and nurse notification protocol. IEP evaluation requested given academic decline. Written documentation provided to parents for school.

18 EDUCATION & SAFETY COUNSELING

1. Seizure first aid taught to mother — stay calm, time the seizure, protect from injury, do not restrain, turn on side if vomiting, call 911 if >5 minutes or injury occurs.
2. Seizure action plan provided in writing for school nurse and teachers.
3. Water safety precautions discussed — no unsupervised bathing or swimming. Shower with door unlocked preferred over bathing.
4. Bicycle and height restrictions — avoid climbing heights unsupervised until seizures are controlled for 3 months.
5. Medication education: oxcarbazepine — take with food, do not miss doses, watch for rash (SJS rare but serious), dizziness, and low sodium symptoms.
6. SUDEP risk counseled appropriately — very low risk at this stage but family educated.
7. MedicAlert bracelet strongly recommended.
8. Driving restrictions — not relevant at age 9 but documented for future counseling.

19 FOLLOW-UP

Timeframe:	Return in 4 weeks with MRI results, EEG, and oxcarbazepine tolerance assessment. Sooner if seizure frequency increases or new seizure type develops.
Return precautions:	Call 911: seizure lasting >5 minutes, back-to-back seizures without recovery, first seizure with injury, or loss of consciousness. Call clinic: new seizure types, severe rash within 4 weeks of starting oxcarbazepine, significant mood changes, or inability to take medication.

20 TIME / BILLING

Total time (minutes):	70 minutes
Counseling time:	30 minutes (seizure first aid education, medication teaching, school planning, family counseling)
Complexity:	High complexity MDM — new diagnosis requiring additional workup (MRI, genetics), AED initiation, multiple chronic conditions, school coordination

Provider name & credentials:	Dr. Caroline E. Webb, MD — Pediatric Neurology
Signature:	C.E. Webb, MD
NPI:	1839204756
Date / Time:	April 27, 2025 — 1:00 PM
Facility:	UNC Children's Pediatric Neurology, 101 Manning Drive, Chapel Hill, NC 27514
Visit type:	New Patient Consultation (99205, High Complexity MDM)