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Seizure Management Plan

Insert jpeg here

1. General information

Name of person experiencing seizures:

Date of birth: Date to review*:

Epilepsy/seizure diagnosis (if known):

Emergency contact details:

2. Tell us about any other medical conditions that might assist someone helping you.

(Examples may include intellectual disability, ASD, cerebral palsy, hydrocephalus, hypoglycaemia, FND etc.)

3. Tell us about any other important information that might assist someone helping you.

(Examples may include location of medical records, non-verbal, uses wheelchair, exhibits behaviours that can be mistaken for seizures, VP shunt, stimming, instructions for VNS, seizure dog etc.)

4. Has emergency epilepsy medication been prescribed?

Yes ○ No ○

If yes, please attach any emergency medication documentation to this plan. In the event of requiring an ambulance, please provide both of these documents to Emergency Responders. If you have been specifically trained to administer the emergency medication, please refer to the Emergency Medication Management Plan.

Where is the emergency medication located?

Client Name DOB:

5. My seizures are triggered by: (if not known, write no known triggers)

6. Changes in my behaviour that may indicate a seizure could occur:
(For example pacing, sad, irritable, poor appetite, usually very mobile but now sitting quietly)

7. My seizure description and seizure support needs:
(Complete a separate row for each type of seizure – use brief, concise language to describe each seizure type.)

Description of seizure Describe what happens immediately before and during the seizure, signs that the seizure is resolving and if seizures occur in a cluster.	**Duration & Frequency** Describe how long seizures typically last, how frequently they occur and whether there is a noticeable pattern to your seizures.	**Is emergency medication prescribed for this type of seizure?**	**When to call an ambulance** Consider seizure length, if occurs in water, if injury has been sustained, if breathing is affected etc. If concerned at any time, call an ambulance
	Duration: **Frequency**: OR Date of last seizure: **Notable seizure pattern** (if any):	Yes ◯ No ◯ If **YES** and you are trained in its administration, refer to the accompanying emergency medication plan. If **not trained,** when calling an ambulance state that it has been prescribed.	

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8. How I want to be supported during a seizure:

Specify the support needed during each of the different seizure types.

(If you are ever in doubt about my health during or after the seizure, call an ambulance)

9. My specific post-seizure support:

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover. How I want to be supported. Describe what my post seizure behaviour may look like.

10. My risk/safety alerts:

For example bathing, swimming, use of helmet, mobility following seizure, overnight support.

Risk	What will reduce this risk for me?

Client Name DOB:

This plan has been developed in collaboration with:

Person 1 Name(s):	Relationship:
Telephone number(s):	

Others involved in plan development:

Person 2 Name(s):	Relationship:
Telephone number(s):	

Endorsement by treating doctor:

Doctor's name:	Telephone:

Signature: Date:

*Date to review

Everyone's epilepsy journey is different. It is best practice to review this plan annually to ensure relevance and currency to the individual needs. The plan should be reviewed more frequently if the person's epilepsy changes.

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Client Name DOB: