



EPILEPSY MANAGEMENT PLAN

Client Name: _____

Date of Birth: _____

Age: _____

Address: _____

Date of plan: _____

Review Dates: _____

Neurologist: _____

Phone: _____

Address: _____

Information about seizures

Description of Epileptic Seizure/s: Describe objectively what this person's seizures look like, duration, frequency and usual resolution, possible triggers

Does the person experience Status Epilepticus (Continual Seizures)

Yes [] No []

Describe how to recognize if the client has gone into Status Epilepticus:
Is PRN medication prescribed?

Yes [] No [] (See page 3)



EPILEPSY MANAGEMENT PLAN

Responding to a seizure

Procedure summary:

Seizure occurs

- Check safety of client
- Check time seizure commences and finishes
- Check clients breathing
- Reassure client
- Place client in the recovery position or assist to a comfortable position
- Record all seizures on individual seizure chart plus usual daily records

Risk and Safety factors Describe actions required by staff in relation to:

Cyanosis (Lack of oxygen during seizure):

Injury, to self or others during seizure activity:

Dentures: Yes [] No [] Procedure:

Helmet: Yes [] No [] Procedure:

Level of supervision while swimming:

Level of supervision when bathing or showering:

Call an Ambulance if:

Write specific information about this person's seizures or the need of emergency intervention:

- 1.
- 2.
- 3.

Epilepsy Management Plan



EPILEPSY MANAGEMENT PLAN

PRN Medication

Name and dose of medication: _____

When is it administered? _____

What is the maximum dose? _____

How is it to be administered? _____

Procedure to be followed if the client refuses PRN medication for Status Epilepticus:

Advise Parent/Carer/Guardian of all Seizures: Yes [] No []

Indicate Appropriate Person: _____

Advise Parent/Carer/Guardian of all seizures requiring transport to Hospital:

Yes [] No []

Advise Manager of all Seizures requiring transport to Hospital:

Yes [] No []

Advise Manager of all seizures resulting in an injury:

Yes [] No []

Current Anticonvulsant Medication:

Name: _____

Dose: _____

Frequency: _____

Route: _____

PRN: _____

Plan Approved by Neurologist/GP:

Signed: _____ Date: _____

Client or Parent/Guardian:

Signed: _____ Date: _____

Manager:

Signed: _____ Date: _____

Epilepsy Management Plan



EPILEPSY MANAGEMENT PLAN

To be signed by each staff member working with the client, including regular casuals:

I have read and understood this Epilepsy Management Plan and will implement this Epilepsy Management Plan

Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:
Name:	Signature:	Date:

Epilepsy Management Plan

Copies of this Epilepsy Management Plan are to be provided to all other agencies or services attended by this client.

Tick when copied or forwarded:

Day Program/PSO	[]
Recreation Program	[]
School	[]
Other	[]



EPILEPSY MANAGEMENT PLAN

Record each seizure in the appropriate box.

If type of seizure is unknown, use the Letter S to record a seizure. If the seizure type is known, use the following codes to identify the seizure type:

- A. Tonic-Clonic B. Absence C. Complex Partial
- D. Atonic E. Myoclonic D. Status Epilticus

Client Name: _____

Year: _____

Date	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												

Epilepsy Management Plan