|  |  |
| --- | --- |
| **Health Support Plan: Seizure** | |
| **Participant Name:** |  |
| **Neurologist:**  **Local GP**  **Psychologist:** |  |
| **Date of Assessment:** |  |
| **Recommended Review Date:** |  |
|  |  |
| **Medical & other Conditions:** |  |
| **Type(s) of Seizures:** |  |
| **Known Triggers:** |  |
| **Seizure Pattern** (What happens before, during and after?): |  |
| **Current Medication:** |  |
| **Likes & Dislikes:** |  |
|  |  |
| How I like to be supported: | |
|  | |
| **Please contact Emergency services on 000 if …**  **In an emergency, please contact :** | |

Participant / Nominee Signature:

Date:

**PARTICIPANT NAME**:

**PLAN DATE**:

# **Staff acknowledgement**

I have read and understood the Seizure Support Plan for this participant.

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Worker Name** | **Worker Signature** | **Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |