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| --- | --- | --- | --- |
| **My Name:** |  | **Date of Birth** |  |
| **Date Plan Written:** |  | **Date to Review:** |  |
|  |
| **Emergency Contact Details** |
| **Name:** |  |
| **Address:** |  |
| **Home Phone:** |  | **Mobile:** |  |
|  |
| **1. General Information** |
| Medication Records Located: |  |
| Seizure Records Located: |  |
| General Support needs Located: |  |
|  |  |
| **2. Has an emergency epilepsy medication or procedure been prescribed?** |  Yes [ ]  No [ ]   |
| The medication authority or emergency plan must be adhered to.Where are these documents located? |  |
|  |  |
| **3. My Seizures are triggered by:**  |  *(if known)* |
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| **4. indications that a seizure could occur**  |  *(eg. pacing, sad, irritability, poor appetite…)* |
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| --- | --- |
| **5. Seizure description and seizure support**  | *(complete a separate row of each type of seizure – use brief, concise language to describe each seizure type.)* |
| **Description** OR name and description of seizure *(make sure you describe what the seizure looks like before, during and after)* | Typical **duration** of seizure | Usual **frequency** of seizure *(state in terms of seizures per month, per year, per day)* | Is **emergency medication prescribed** for this type of seizure? | When to call an **ambulance****If you are trained in emergency medication administration refer to the Emergency Medication Plan and the Medication Authority** |
|  |  |  | [ ]  Yes[ ]  No | *If you are untrained in emergency PRN, call ambulance when:* |
|  |  |  | [ ]  Yes[ ]  No | *If you are untrained in emergency PRN, call ambulance when:* |
|  |  |  | [ ]  Yes[ ]  No | *If you are untrained in emergency PRN, call ambulance when:* |
|  |  |  |  |  |
| **6. 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 the person’s health during or after the seizure, call an ambulance)** |
|  |
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|  |
| **7. SPECIFY POST-SEIZURE SUPPORT** | (state how a support person would know when the person has regained their usual awareness and how long it typically takes for the person to fully recover. Describe what the person’s post seizure behaviour may look like) |
|  |
|  |
|  |
| **8. RISK/SAFETY ALERTS**  | *(eg. bathing, swimming, use of helmet, mobility following seizure..)* |
| **RISK** | **WHAT WILL REDUCE THIS RISK FOR ME?** |
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| --- | --- |
| **DO I NEED ADDITIONAL OVERNIGHT SUPPORT?** |  Yes [ ]  No [ ]   |
| **If ‘Yes”, describe:** |
|  |
| **9. ENDORSEMENT BY TREATING DOCTOR**  |
| YOU DOCTOR’S NAME |  |
| SIGNATURE |  |
| PHONE |  | DATE |  |
|  |  |  |  |
| **10. THIS PLAN HAS BEEN CO-ORDINATED BY**  |
| NAME |  |
| PHONE NUMBERS |  |
| ORGANISATION *(if any)* |  |
| ASSOCATION WITH PERSON*(eg. Treating doctor, parent, key worker in group home, case manager)* |  |

Participant / Nominee Signature:

Date:

**PARTICIPANT NAME**:

**PLAN DATE**:

# Staff acknowledgement

I have read and understood the Epilepsy Management Plan for this participant.

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