**THIS EPILEPSY MANAGEMENT PLAN TEMPLATE is available at** [Epilepsy Management Plan - Epilepsy Queensland](https://www.epilepsyqueensland.com.au/about-epilepsy-epilepsy-queensland/seizure-first-aid/epilepsy-management-plan)

**The Plan has not been endorsed by Epilepsy Queensland.**

**The plan has been prepared by:**

**NAME: PHONE:**

**EPILEPSY PLAN COORDINATOR (if applicable):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | Photo | | |
| **PLAN DATE** | | | |
| DATE |  | DATE TO REVIEW |  |
| **PERSONAL DETAILS** | | | |
| DATE OF BIRTH |  | | |
| ADDRESS |  | | |
| PHONE |  | | |
| **EMERGENCY CONTACT** | | | |
| NAME |  | | |
| RELATIONSHIP |  | | |
| EMAIL |  | | |
| PHONE |  | | |
|  |  | | |
| **SECONDARY CONTACT** | | | |
| NAME |  | | |
| RELATIONSHIP |  | | |
| PHONE |  | | |

**MEDICAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **Epilepsy Medication** | **Other Medications** |
|  |  |  |

**SEIZURE DESCRIPTION & FIRST AID**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EPILEPSY DIAGNOSIS:** | | | | |
| **SEIZURE TRIGGERS:**  **Example:**   * Poor sleep quality * Heat * Not enough fluid | | |  | |
| **SEIZURE HISTORY:** | | | | |
| **Seizure Description** | **Duration** | **Frequency** | | **Seizure First Aid** |
| Type: TONIC-CLONIC SEIZURES  Before seizure:  During seizure:  After the seizure: |  |  | | TONIC-CLONIC SEIZURES   1. **Time** the seizure    1. Support her head    2. Put something soft under head    3. Loosen tight clothing 2. **Gently** roll onto side 3. **Stay** with the person until fully recovered 4. **Reassure & Reorientate** 5. **Respond** to any injuries 6. **Record** in seizure log (what happened before, during & after)   **DO NOT** restrain  **DO NOT** put anything in the mouth  **DO NOT** give food or drink until fully recovered |
| Type: ATONIC SEIZURES  Before:  During:  After: |  |  | | TONIC SEIZURES   1. **Time** the Seizure 2. **Protect from injury**    1. Remove objects    2. Support head    3. Roll on his side 3. **Stay** with the person until he has fully recovered 4. **Reassure & Reorientate** after the seizure is over**,** using simple and clear language 5. **Respond** to any injuries that he may have been sustained during the seizure 6. **Record** seizure details in log |
| Type: ABSENCE SEIZURES  Before:  During:  After: |  |  | | ABSENCE SEIZURES   1. **Recognise** that the seizure has occurred 2. **Reassure & re-orientate** to environment 3. **Repeat** any information missed 4. **Stay** with the person until fully recovered |
| Type: FOCAL SEIZURES  Before:  During:  After: |  |  | | FOCAL SEIZURES WITH IMPAIRED AWARENESS   1. **Time** the seizure 2. **Protect** from injury  * Remove objects that the person may bump into * Redirect away from dangers * Encourage to sit down  1. **Stay** until the person has fully recovered 2. **Reassure & reorientate** 3. **Respond** to any injuries 4. **Record** in seizure log   **DO NOT** restrain  **DO NOT** put anything in mouth  **DO NOT** give anything eat or drink until fully recovered |
| Type: MYOCLONIC SEIZURES  Before:  During: |  |  | | MYOCLONIC SEIZURES   1. **Time** the Seizure 2. **Protect from injury** 3. **Stay** with the person until fully recovered 4. **Reassure & Reorientate** after the seizure is over**,** using simple and clear language 5. **Respond** to any injuries that he may have been sustained during the seizure 6. **Record** seizure details in log |
| **WHEN TO CALL AN AMBULANCE**   * If you have any doubts * If a convulsive seizure lasts more than …. minutes * If non-convulsive events last more than .… minutes * Clusters of seizures – that is, more than 3 in 60mins * The seizure occurs in water or XXX is eating or drinking at the time * If the person is injured (particularly a head injury) * If the person experiences a new seizure type   **.** | | | | |

**Epilepsy Queensland recommends this plan be reviewed and signed by the person’s doctor. Epilepsy Queensland also recommends that this plan should be updated whenever there is a change in care & at minimum should be reviewed 12 monthly.**

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| **ENDORSEMENT BY ONE TREATING DOCTOR/EPILEPSY SPECIALIST (only ONE endorsement is required)** | | | |
| GP |  | | |
| ADDRESS |  | | |
| PHONE |  | | |
| SIGNATURE |  | DATE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **ENDORSEMENT BY ONE TREATING DOCTOR/EPILEPSY SPECIALIST (only ONE endorsement is required)** | | | |
| NEUROLOGIST |  | | |
| ADDRESS |  | | |
| PHONE |  | | |
| SIGNATURE |  | DATE |  |

|  |  |
| --- | --- |
| **EPILEPSY PLAN COORDINATOR** | |
| NAME |  |
| PHONE |  |

|  |  |
| --- | --- |
| **PEOPLE INVOLVED IN PREPARATION OF PLAN** | |
| NAME |  |
| RELATIONSHIP |  |