**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**

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| --- |
| **EPILEPSY DIAGNOSIS:** |
| **SEIZURE TRIGGERS:** **Example:** * Poor sleep quality
* Heat
* Not enough fluid
 |  |
| **SEIZURE HISTORY:** |
| **Seizure Description** | **Duration** | **Frequency** | **Seizure First Aid** |
| Type: TONIC-CLONIC SEIZURESBefore seizure: During seizure: After the seizure:  |  |  | TONIC-CLONIC SEIZURES1. **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 SEIZURES1. **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 SEIZURESBefore: 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 AWARENESS1. **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 SEIZURES1. **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 |  |

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

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

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