NAME:

This plan has been developed in consultation with family & carers & is current & accurate at the date completed. 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.

Photo

|  |
| --- |
| **PLAN DATE** |
| DATE |  | DATE TO REVIEW |  |
| **PERSONAL DETAILS** |
| NAME |  |
| DATE OF BIRTH |  |
| ADDRESS |  |
| **EMERGENCY CONTACT** |
| NAME |  |
| RELATIONSHIP |  |
| PHONE |  |
| ADDRESS |  |

**MEDICAL HISTORY:**

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

**SEIZURE DESCRIPTION & FIRST AID**

|  |
| --- |
| **EPILEPSY DIAGNOSIS:**  |
| **SEIZURE TRIGGERS:**  |
| **Seizure Description***New line for each different seizure presentation* | **Duration** | **Frequency** | **Seizure First Aid** |
| **Name of Seizure*** Before the seizure:
* During the seizure:
* After the seizure:
 |  |  |  |
|  |  |  |  |
| **WHE WHEN TO CALL AN AMBULANCE*** If you have any doubts
* If a seizure lasts more than 5 minutes
* Clusters of seizures (more than is usual for XXXXX)
* The seizure occurs in water or XXXXX is eating or drinking at the time
* If XXXXX is injured (particularly a head injury)
* If XXXXX experiences a new seizure type
 |

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

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

|  |
| --- |
| **PEOPLE INVOLVED IN PREPARATION OF PLAN** |
| NAME |  |
| RELATIONSHIP |  |
| PHONE |  |
|  |
| NAME |  |
| ORGANISATION |  |
| PHONE |  |
| Email |  |
|  |
| NAME |  |
| ORGANISATION |  |
| PHONE |  |
| Email |  |