

# SEIZURE MANAGEMENT PLAN

Insert jpeg  
image  
here

Name of person living with seizures:

Date of birth:

Date plan written:

Date to review:

## 1. General information



Medication records located:

Seizure records located:

General support needs document located:

Epilepsy diagnosis (if known):

## 2. Has seizure emergency medication been prescribed?      Yes      No

If yes, the medication authority or emergency medication plan must be attached and followed by anyone specifically trained



These documents are located:

## 3. My seizures are triggered by: (if not known, write no known triggers)





## 4. Changes in my behaviour that may indicate a seizure could occur:

(For example pacing, sad, irritability, poor appetite, usually very mobile but now sitting quietly)



## 5. My seizure description and seizure support needs:

(Complete a separate row for each type of seizure – use brief, concise language to describe each seizure type.)

 <b>Description of seizure</b> (Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster)	<b>Typical duration of seizure</b> (seconds/minutes)	<b>Usual frequency of seizure</b> (state in terms of seizures per month, per year or per day)	<b>Is emergency medication prescribed for this type of seizure?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>When to call an ambulance</b> If you are trained in emergency medication administration refer to the emergency medication plan and the medication authority   If you are untrained in emergency medication, 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 my health during or after the seizure, call an ambulance)



## 7. My specific post-seizure support:

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover. How I want to be supported. Describe what my post seizure behaviour may look like.



## 8. My risk/safety alerts:

For example bathing, swimming, use of helmet, mobility following seizure.



Risk

What will reduce this risk for me?

9. Do I need additional overnight support? Yes ☐ No ☐

If 'yes' describe:



This plan has been co-ordinated by:



Name:

Organisation (if any):

Telephone numbers:

Association with person: (For example treating doctor, parent, key worker in group home, case manager)

Client/parent/guardian signature (if under age):

Endorsement by treating doctor or specialist:



Doctor or specialists name:

Telephone:

Doctor or specialists signature:

Date:

Epilepsy New Zealand - Support and Information Line 0800 37 45 37