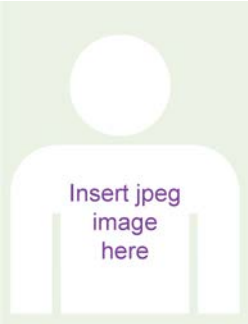
Epilepsy: Know me, Support me.



Epilepsy Management Plan

Name of person living with epilepsy:		
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 emergency epilepsy medication been prescribed? Yes ☐ No ☐

If yes, the medication authority or emergency medication plan must be attached and followed*, if you are 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.)

Description of seizure (Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster)	**Typical duration of seizure** (seconds/ minutes)	**Usual frequency of seizure** (state in terms of seizures per month, per year or 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 medication, call ambulance when:

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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:

Your doctor's name:	
Telephone:	

Doctor's signature:	Insert jpeg here	Date: