The E?!lepsy Centre
South Australia and the Northern Territory

Epilepsy Management Plan

This plan should be current, accurate and easy to understand. The plan should be developed by the person or people who have the most knowledge and experience of the person's epilepsy and seizures. It is very important for the person with epilepsy to be part of this planning process. A team approach to developing a plan is often helpful. The Epilepsy Centre recommends this plan be reviewed by the person's doctor.

Attach photo if required

Epilepsy Management Plan for _____

1. DATE

2. DATE TO REVIEW

3. DATE OF BIRTH

CURRENT WEIGHT (kg)

ADDRESS

POSTCODE

PHONE

MOBILE

EMAIL

4. FIRST EMERGENCY CONTACT NAME

RELATIONSHIP

PHONE (HOME)

PHONE (WORK)

MOBILE

EMAIL

SECOND EMERGENCY CONTACT NAME

RELATIONSHIP

PHONE (HOME)

PHONE (WORK)

MOBILE

EMAIL

5. CURRENT EPILEPSY MEDICATION:

NAME (e.g. sodium valproate)	DOSE REGIME (e.g. 8am–200mg/ 8pm–400mg)

COMMENTS:

6. HAS AN EMERGENCY EPILEPSY MEDICATION BEEN PRESCRIBED?
(Must attach separate Emergency Medication Management Plan) YES ☐ NO ☐

7. EPILEPSY DIAGNOSIS (if known):

SEIZURE DESCRIPTION:
Name the type of seizure, if known, but more importantly, describe what happens before, during and after the seizure, remembering to include separate descriptions if the person has more than one type of seizure. Also, provide information about the duration and frequency of seizures.

Use additional page if more space is required (available on request from the Epilepsy Centre).

8. SEIZURE TRIGGERS: (if known)

9. OTHER SEIZURE TREATMENTS: Surgery ☐ Ketogenic Diet ☐ Vagal Nerve Stimulator (VNS) ☐
Specific instructions/relevant information

10a. OTHER MEDICAL CONDITIONS:

10b. OTHER CURRENT MEDICATION

NAME	DOSE REGIME (e.g. 8am–200mg / 8pm–400mg)

11. SEIZURE FIRST AID PROCEDURE SPECIFIC TO THIS PERSON:

12. WHEN TO CALL AN AMBULANCE: 

13. POST-SEIZURE MONITORING:

14. OTHER SPECIFIC INSTRUCTIONS:

15. ENDORSEMENT BY ONE TREATING DOCTOR / EPILEPSY SPECIALIST: (only ONE endorsement is required)

YOUR DOCTOR / SPECIALIST'S NAME

SIGNATURE

PHONE MOBILE DATE

EPILEPSY PLAN COORDINATOR NAME

SIGNATURE ORGANISATION

PHONE MOBILE DATE

16. PEOPLE INVOLVED IN PREPARATION OF THIS PLAN:

PERSON WITH EPILEPSY ☐ YES ☒ NO

CONTACT NAME

RELATIONSHIP

PHONE

MOBILE

EMAIL

CONTACT NAME

POSITION

ORGANISATION

PHONE

MOBILE

EMAIL

CONTACT NAME

POSITION

ORGANISATION

PHONE

MOBILE

EMAIL

17. COPIES OF THIS PLAN ARE LOCATED AT:

DOCTOR

ADDRESS

PHONE

EMAIL

SCHOOL

STAFF

CONTACT

ADDRESS

PHONE

EMAIL

OTHER

CONTACT

ADDRESS

PHONE

EMAIL

PARENT / GUARDIAN / CLIENT AUTHORISATION

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian or client _____ Signature _____ Date _____
Family name (please print) First name (please print)