Epilepsy Management Plan



Epilepsy Management Plan

Attach photo if required

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.

Epilepsy Management Plan for

1. DATE 2. DATE TO REVIEW

1. DATE OF BIRTH CURRENT WEIGHT (kg)

ADDRESS POSTCODE

PHONE MOBILE

EMAIL

1. FIRST EMERGENCY CONTACT NAME

RELATIONSHIP PHONE (HOME)

PHONE (WORK) MOBILE

EMAIL

SECOND EMERGENCY CONTACT NAME

RELATIONSHIP PHONE (HOME)

PHONE (WORK) MOBILE

EMAIL

1. CURRENT EPILEPSY MEDICATION:

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

COMMENTS:

1. HAS AN EMERGENCY EPILEPSY MEDICATION BEEN PRESCRIBED?

(Must attach separate Emergency Medication Management Plan) YES NO

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1. 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).

1. SEIZURE TRIGGERS: (if known)
2. OTHER SEIZURE TREATMENTS: Surgery Specific instructions/relevant information

10a. OTHER MEDICAL CONDITIONS:

10b. OTHER CURRENT MEDICATION

Ketogenic Diet

Vagal Nerve Stimulator (VNS)

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

1. SEIZURE FIRST AID PROCEDURE SPECIFIC TO THIS PERSON:
2. WHEN TO CALL AN AMBULANCE:
3. POST-SEIZURE MONITORING:
4. OTHER SPECIFIC INSTRUCTIONS:
5. 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:

17. COPIES OF THIS PLAN ARE LOCATED AT:

**DOCTOR**

**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

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)

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