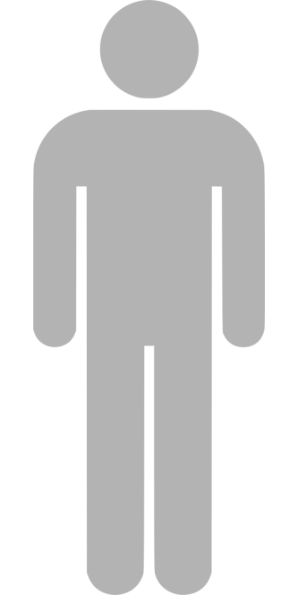
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Place Image Here

**Epilepsy: Know Me, Support Me**

**Epilepsy Management Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of person living with epilepsy: | | | |
|  | | | |
| Date of birth: text | | Date plan written: text | Date to review: text |

|  |  |
| --- | --- |
| A grey and white symbol  Description automatically generated with medium confidence | 1. **General Information** |

|  |  |
| --- | --- |
| Medical Information Located: | text |
| Epilepsy Management Plan Located**:** | text |
| Medical Conditions (is epilepsy the primary or a secondary diagnosis): | text |
| Medications: | text |

|  |  |
| --- | --- |
|  | 1. **Has emergency epilepsy medication been prescribed? Yes  No** |
| If yes, the medication authority or emergency management plan must be attached and followed, if you are specifically trained. | |
|  | |
|  | |
| Emergency Medication Management Plan Location: text | |
| Current Weight: text | |

|  |  |
| --- | --- |
|  | **3. My seizures are triggered by:** |
| For example, heat, light, being unwell, fatigue. | |
|  | |
| text | |

|  |  |
| --- | --- |
|  | **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 | |
|  | |
| text | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**  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 EMMP and the medication authority |
| text | text | text | Yes  No | If you are untrained in emergency medication call ambulance when:  text |

|  |  |  |
| --- | --- | --- |
| A grey hand with a lightning bolt  Description automatically generated | **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. | | |
| **Seizure Type** | | **Support Needed** |
| text | | text |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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. | | | |
| **Seizure Type** | | **Post-Seizure Behaviour** | **Support Needed** |
| text | | text | text |

|  |  |  |
| --- | --- | --- |
| A triangle with a exclamation mark  Description automatically generated | **8. My risk/safety alerts:** | |
| For example, bathing, swimming use of helmet, mobility following seizure. | | |
| **Risk** | | **What will reduce risk for me** |
| text | | text |

|  |  |
| --- | --- |
| C:\Users\Student\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\MNTELR76\768px-Red_Silhouette_-_Hand_Shaking.svg[1].png | **9. Do I need additional support: Yes  No** |
| If yes describe, for example, wheelchair, supervision with stairs, non-verbal. | |
| text | |

|  |  |
| --- | --- |
| **This plan has been co-ordinated by:** | |
| Name: | text |
| Organisation: | text |
| Telephone numbers: | text |
| Association with person:  For example, treating doctor, parent, case manager. | text |

|  |  |
| --- | --- |
| Individual’s signature: text  Parent/Guardian if under 18 | Date: text |

|  |  |
| --- | --- |
| **Primary contact:** | |
| Name:text | Relationship: text |
| Telephone:text | |

|  |  |
| --- | --- |
|  | **Endorsement by medical practitioner:** |
| Your medical practitioner’s name:text | |
| Telephone:text | |

|  |  |  |
| --- | --- | --- |
| Prescribing medical practitioner’s signature:text  Parent/Guardian if under 18 | | Date: text |
|  |  | |

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A close-up of a logo

Description automatically generated