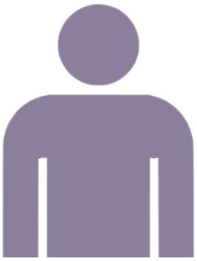
epilepsy tasmania TASMANIA'S VOICE FOR EPILEPSY

Epilepsy: Know Me, Support Me

Epilepsy Management Plan



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

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

2. 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

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

8. My risk/safety alerts:

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

Risk	What will reduce risk for me
text	text

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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