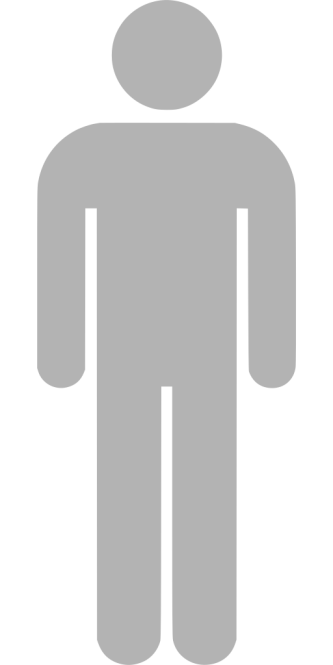
****

Place Image Here

**Epilepsy: Know Me, Support Me**

Insert jpeg image here

**Epilepsy Management Plan**

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

**1. General Information**

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

**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: |  |
|  | Current Weight: |  |

**3. My seizures are triggered by:**

For example, heat, light, being unwell, fatigue

|  |
| --- |
|  |

**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**  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 |
|  |  |  | Yes  No | If you are untrained in emergency medication call ambulance when: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |
|  |  |  | Yes  No | If you are untrained in emergency medication call ambulance when: |

**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** |
|  |  |
|  |  |
|  |  |  |

**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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**8. My risk/safety alerts:**

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

|  |  |
| --- | --- |
| **Risk** | **What will reduce risk for me** |
|  |  |
|  |  |
|  |  |
|  |  |

**9. Do I need additional support? Yes  No**

If yes describe. For example wheelchair, supervision with stairs, non-verbal

|  |
| --- |
| C:\Users\Student\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\MNTELR76\768px-Red_Silhouette_-_Hand_Shaking.svg[1].png |

**This plan has been co-ordinated by:**

|  |  |
| --- | --- |
| Name: | Organisation: |
| Telephone numbers: |  |
| Association with person:  For example treating doctor, parent, case manager |  |

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

**Primary contact:**

|  |  |
| --- | --- |
| Name: | Relationship: |
| Telephone: | |

**Endorsement by treating doctor:** 

|  |  |  |
| --- | --- | --- |
| Your doctor’s name: | | |
| Telephone: | | |
|  | |  |
| Doctor’s Signature: | Date | |