



# 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 <input type="checkbox"/> No <input type="checkbox"/>	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
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### 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
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### 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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