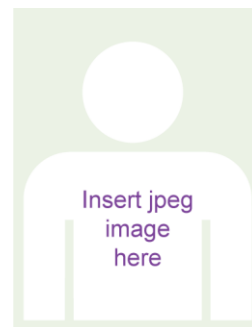


# EPILEPSY: KNOW ME, SUPPORT ME.



## Epilepsy Management Plan

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

### 1. General information



Medication records located:
Seizure records located:
General support needs document located:
Epilepsy diagnosis (if known):

### 2. Has emergency epilepsy medication been prescribed? Yes No

If yes, the medication authority or emergency medication plan must be attached and followed\*, if you are specifically trained.



These documents are located:
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### 3. My seizures are triggered by: (if not known, write no known triggers)



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### 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)



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### 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.)

 <b>Description of seizure</b> (Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster)	<b>Typical duration of seizure</b> (seconds/minutes)	<b>Usual frequency of seizure</b> (state in terms of seizures per month, per year or per day)	<b>Is emergency medication prescribed for this type of seizure?</b>	<b>When to call an ambulance</b> If you are trained in emergency medication administration* refer to the emergency medication plan and the medication authority
				Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)



**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. How I want to be supported. Describe what my post seizure behaviour may look like.



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

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



Risk	What will reduce this risk for me?

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

If 'yes' describe:



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

Name:	Organisation (if any):
Telephone numbers:	
Association with person: (For example treating doctor, parent, key worker in group home, case manager)	
Client/parent/guardian signature (if under age):	

**Endorsement by treating doctor:**



Your doctor's name:	
Telephone:	

Doctor's signature:	Insert jpeg here	Date:
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