

Epilepsy Management Plan

This plan should be current, accurate and easy to understand. The plan should be developed by the person or people who have the most knowledge and experience of the person's epilepsy and seizures. It is very important for the person with epilepsy to be part of this planning process. A team approach to developing a plan is often helpful. The plan should be reviewed and signed by the person's doctor.

Attach photo
if required

Epilepsy Management Plan for _____

1. DATE _____ 2. DATE TO REVIEW _____

3. DATE OF BIRTH _____ CURRENT WEIGHT (kg) _____

ADDRESS _____ POSTCODE _____

PHONE _____ MOBILE _____

EMAIL _____

4. FIRST EMERGENCY CONTACT NAME _____

RELATIONSHIP _____ PHONE (HOME) _____

PHONE (WORK) _____ MOBILE _____

EMAIL _____

SECOND EMERGENCY CONTACT NAME _____

RELATIONSHIP _____

PHONE _____ MOBILE _____

EMAIL _____

5. CURRENT EPILEPSY MEDICATION:

NAME (e.g. sodium valproate)	DOSE REGIME (e.g. 8am-200mg / 8pm-400mg)

COMMENTS:

6. HAS AN EMERGENCY EPILEPSY MEDICATION BEEN PRESCRIBED?
(Must attach separate Emergency Medication Management Plan) YES NO

8. SEIZURE TRIGGERS: (if known)

9. OTHER SEIZURE TREATMENTS: Surgery Ketogenic Diet Vagal Nerve Stimulator (VNS)
Specific instructions/relevant information

10a. OTHER MEDICAL CONDITIONS:

10b. OTHER CURRENT MEDICATION

NAME	DOSE REGIME (e.g. 8am-200mg / 8pm-400mg)

11. SEIZURE FIRST AID PROCEDURE SPECIFIC TO THIS PERSON:

12. WHEN TO CALL AN AMBULANCE:



13. POST-SEIZURE MONITORING:

14. OTHER SPECIFIC INSTRUCTIONS:

15. ENDORSEMENT BY ONE TREATING DOCTOR / EPILEPSY SPECIALIST: (only ONE endorsement is required)

YOUR DOCTOR / SPECIALIST'S NAME _____

SIGNATURE _____

PHONE _____ MOBILE _____ DATE _____

EPILEPSY PLAN COORDINATOR

NAME _____

PHONE _____ MOBILE _____ DATE _____

16. PEOPLE INVOLVED IN PREPARATION OF THIS PLAN:

PERSON WITH EPILEPSY YES NO

CONTACT NAME _____

RELATIONSHIP _____

PHONE _____

MOBILE _____

EMAIL _____

CONTACT NAME _____

POSITION _____

ORGANISATION _____

PHONE _____

MOBILE _____

EMAIL _____

CONTACT NAME _____

POSITION _____

ORGANISATION _____

PHONE _____

MOBILE _____

EMAIL _____

CONTACT NAME _____

POSITION _____

ORGANISATION _____

PHONE _____

MOBILE _____

EMAIL _____

17. COPIES OF THIS PLAN ARE LOCATED AT:

DOCTOR _____

ADDRESS _____

PHONE _____

EMAIL _____

SCHOOL _____

STAFF CONTACT _____

ADDRESS _____

PHONE _____

EMAIL _____

OTHER _____

CONTACT _____

ADDRESS _____

PHONE _____

EMAIL _____

OTHER _____

CONTACT _____

ADDRESS _____

PHONE _____

EMAIL _____