**Seizure Management Plan for Clinicians**

|  |  |
| --- | --- |
| Patient name | Click or tap here to enter text. |
| Date of birth | Click or tap to enter a date. |
| Address | Click or tap here to enter text. |
| Treating hospital | Click or tap here to enter text. |
| Hospital URN | Click or tap here to enter text. |
| Weight (date) | Click or tap here to enter text. |

|  |
| --- |
| Click or tap here to enter text. **has epilepsy and may present to hospital with seizures.** |

|  |
| --- |
| **Epilepsy diagnosis:** Choose an item. |

**Epilepsy and comorbidities**

|  |  |  |
| --- | --- | --- |
| **Seizure type(s)**  *See page 4 for description of each seizure type* | Choose an item.  Choose an item.  Choose an item. | Choose an item.  Choose an item.  Choose an item. |
| **Epilepsy cause** | Click or tap here to enter text. | |
| **Comorbidities** | Choose an item.  Choose an item.  Choose an item. | Choose an item.  Choose an item.  Choose an item. |
| Other (*please specify*): Click or tap here to enter text. | |

|  |  |
| --- | --- |
| **Current Epilepsy treatments** | Click or tap here to enter text. |
| **Other regular medication** | Click or tap here to enter text. |
| **Allergies or adverse drug reactions** | Click or tap here to enter text. |

**Treatments**

**Care team**

|  |  |
| --- | --- |
| **Neurologist name** | Click or tap here to enter text. |
| **Paediatrician name** | Click or tap here to enter text. |
| **Other care team members** | Click or tap here to enter text. |

**Seizure exacerbation**

|  |  |
| --- | --- |
| **Likely exacerbation type(s)** | |
| Seizure cluster  Prolonged seizure/ Status epilepticus  Tonic status epilepticus | Non-convulsive status epilepticus (absence)  Non-convulsive status epilepticus (myoclonic)  Non-epileptic events |
| Other (*please specify*): Click or tap here to enter text. | |

**Qr code

Description automatically generatedEMERGENCY SEIZURE MANAGEMENT PLAN**

Follow individualised management plan below

Follow ambulance and APLS guidelines →

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Treatment** | **Route** | | | **Dose**  **(mg or mg/kg)** | **Indication** | **Alerts** |
| **STEP 1** |  | | |  | | | | |
| Choose an item. |  | | | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| **STEP 2** |  | | |  | | | | |
| Choose an item. |  | | | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| **STEP 3** |  | | |  | | | | |
| Choose an item. |  | | | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| **STEP 4** |  | | |  | | | | |
| Choose an item. |  | | | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| **STEP 5** |  | |  | | | | | |
| Choose an item. |  | | | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |

**EMERGENCY MANAGEMENT ALERTS**

**Is additional emergency treatment to be given routinely once seizures have ceased?**

No

|  |  |  |
| --- | --- | --- |
| **Treatment name** | **Dose** | **Indication** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Yes (please specify below):

**Emergency treatments to avoid or give cautiously**

|  |  |  |  |
| --- | --- | --- | --- |
| **Emergency treatment** | **Avoid or caution?** | **Reason** | **Details** |
| Click or tap here to enter text. | Choose an item. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Choose an item. | Choose an item. | Click or tap here to enter text. |
| N/A | | | |

**Other management considerations**

|  |
| --- |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| N/A |

**Please seek neurologist advice for:**

|  |
| --- |
| All epilepsy-related hospital presentations |
| Seizures ongoing despite hospital treatment |
| If it is unclear whether seizures are ongoing  Other (*please specify*): Click or tap here to enter text. |

**Neurology team contact details**

|  |
| --- |
| Contact name/position: Click or tap here to enter text. |
| Phone: Click or tap here to enter text. |
| Location: Click or tap here to enter text. |

**Plan written by**

**SIGNATURE OR STAMP**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Role | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |
| Date for review | Click or tap to enter a date. |

**Section for caregiver to complete**

**Emergency contact people**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship to child** | **Phone number** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Descriptions of my child’s seizures**

|  |  |  |
| --- | --- | --- |
| **Seizure type** | **Typical duration of seizure** | **Description:** What happens before, during and after the seizure? How can you tell the seizure has finished? |
| Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |

**Things I would like health professionals to know about my child**

|  |  |
| --- | --- |
| **Communication** | Click or tap here to enter text. |
| **Mobility** | Click or tap here to enter text. |
| **Support needs in hospital** (eg to avoid/reduce distress, maximise comfort, avoid seizure triggers etc) | Click or tap here to enter text. |
| **Other** | Click or tap here to enter text. |

**FAMILY SECTION COMPLETED BY**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Relationship to child | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |