**EPILEPSY MANAGEMENT PLAN Date Plan Developed:** Click here to enter a date.

 **Plan Developed by:**Click here to enter text.

**Name of Participant:** Click here to enter text.

Insert Photo Here


**Address:** Click here to enter text.

**Home** **Phone No:** Click here to enter text. **Mobile No:** Click here to enter text.

**Date of Birth:** Click here to enter a date.

**Allergies :** Click here to enter text.

**Contact Person:** Click here to enter text. **Phone:** Click here to enter text.

|  |  |
| --- | --- |
| **Neurologist Name,****Address, Phone Number, and Date Last Seen** | Click here to enter text. |
| **GP Name Address, Phone Number, and Date Last Seen** | Click here to enter text. |
| Please give a brief description of the persons usual seizure type, state the date of the last known seizure, and the frequency of occurrence: (e.g. they fall to the ground, convulse, usually have one seizure every six month, last seizure April 2007)Click here to enter text. |
| **Does the person have any contributing factors that may lead to them having a seizure:** (e.g. when they are tired because they have a cold or have exercised more than usual, hormonal changes due to menstruation)Click here to enter text. |
| **Does the person experience any sensations that enable them or staff to know that they will have a seizure soon, if so please describe these:**Click here to enter text. |
| **Does the person experience Status Epilepticus (continual seizures)?**Click here to enter text. | Choose an item.  |
| **Does the person suffer from Cyanosis (lack of oxygen during seizure)?**Click here to enter text. | Choose an item.  |
| **CALL AN AMBULANCE IF** – (please give specific information about this persons seizures and the need for emergency intervention) Click here to enter text. |
| **Potential injury to self or others during seizure activity**– Dentures Choose an item. Helmet Choose an item.**Specific procedures to prevent injuries for this individual:** (e.g. postural belt on wheelchair, lap sash seat belt in vehicle, stove guard)Click here to enter text. |
| **Level of supervision required when swimming, bathing or showering:**Click here to enter text. |
| **PRN MEDICATION** |
| **Is PRN medication prescribed** Choose an item. | Name of PRN Medication: Click here to enter text. |
| In what circumstances is the PRN to be administered: Click here to enter text. | **How is the PRN to be given:**Click here to enter text. | **How often should the PRN be given:** Click here to enter text. |
| Procedure to be followed if the person refuses PRN medication for Status Epilepticus:Click here to enter text. |

|  |
| --- |
| **Current Anticonvulsant Medications** |
|

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DRUG NAME(GENERIC) | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| DOSAGE | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| FREQUENCY | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| ROUTE | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

 |

# Past Medications

**If the Participant has a Long History of Epilepsy, make a note of previous medications and the reasons for changes, if known:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Period of Time on Medication** | **Reason for Change** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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**Epilepsy Management Plan Approval:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan Read and Understood by:** | **Name:** | **Signed:** | **Date:** |
| Neurologist |  |  |  |
| GP |  |  |  |
| Parent/Carer/Person Responsible |  |  |  |
| Participant |  |  |  |
| NWDS Coordinator |  |  |  |

**Review of the Epilepsy Management Plan**

Every individuals Epilepsy Management Plan is reviewed with each change of medication, change in seizures, upon carer advice and a minimum of every 12 months.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Review** | **Reasons for changes**  | **Carer Name** | **Signature** |
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**Other Areas of NWDS That Need to be Sent the Updated Epilepsy Management Plan**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Area**  | **Tick to Send** | **Date sent** | **By Whom** | **Area** | **Tick to Send** | **Date Sent** | **By Whom** |
| Conie Ave PSP  |  |  |  | Opal Cottage |  |  |  |
| Hadpac Programs |  |  |  | Lavender Cottage |  |  |  |
| Gemhill Cottage |  |  |  | Other |  |  |  |

**Staff Sign Off**

This Plan is to be read and signed by every staff member working with this individual.

**Declaration:**

I have read and understood this epilepsy management plan and will implement it in accordance with the NWDS Epilepsy Policy.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Staff Name** | **Signature** | **Date** | **Staff Name** | **Signature** | **Date** |
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