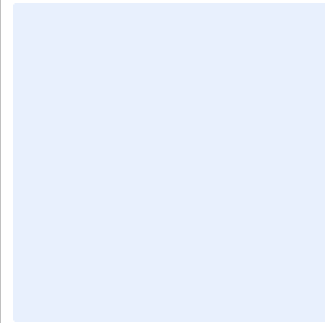



Epilepsy Management Plan

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 Epilepsy Foundation of Victoria recommends this plan be reviewed and signed by the person's doctor.

Please attach a photograph of the person with epilepsy in the space provided.



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 (HOME)	
PHONE (WORK)		MOBILE	
EMAIL			
5. CURRENT EPILEPSY MEDICATION:			
NAME (e.g. sodium valproate)		DOSE REGIME (e.g. 8am-200mg / 8pm-400mg)	
COMMENTS:			
6. HAS MIDAZOLAM OR RECTAL VALIUM BEEN PRESCRIBED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
(If yes, the Midazolam or Rectal Valium Emergency Medication Management Plan must be attached)			

7. EPILEPSY DIAGNOSIS (if known):				
SEIZURE DESCRIPTION:				
<i>Name the type of seizure, if known, but more importantly, describe what happens before, during and after the seizure, remembering to include separate descriptions if the person has more than one type of seizure. Also, provide information about the duration and frequency of seizures.</i>				
8. SEIZURE TRIGGERS: (if known)				
9. OTHER SEIZURE TREATMENTS: Surgery <input type="checkbox"/> Ketogenic Diet <input type="checkbox"/> Vagal Nerve Stimulator (VNS) <input type="checkbox"/>				
<i>Specific instructions/relevant information</i>				
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:				
<i>Only ONE endorsement is required</i>				
YOUR DOCTOR'S / 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 <input type="checkbox"/>	NO <input type="checkbox"/>
-----------------------------	-------------------------------------	------------------------------------

CONTACT NAME		RELATIONSHIP	
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		POSTCODE	
PHONE		MOBILE	
EMAIL			
SCHOOL			
STAFF CONTACT			
ADDRESS		POSTCODE	
PHONE		MOBILE	
EMAIL			
OTHER			
CONTACT			
ADDRESS		POSTCODE	
PHONE		MOBILE	
EMAIL			
OTHER			
CONTACT			
ADDRESS		POSTCODE	
PHONE		MOBILE	
EMAIL			

For more information Epilepsy Foundation of Victoria 818 Burke Road Camberwell VIC 3124
 phone (03) 9805 9111 or 1300 852 853 fax (03) 9882 7159 web www.epinet.org.au