**Seizure Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my diagnoses related to seizures:** | List all diagnoses related to seizures, or note if there are none. |
| **I am allergic to these things:** | List all known allergies and sensitivities, or note if there are none. |
| **The goal of this Healthcare Plan is:** | [ ]  I will not experience any injuries or complications related to seizures for XX days/months for the duration of the ISP year.[ ]  I will not experience any seizures for XX days/months for the duration of the ISP year. [ ]  Describe any other goal related to managing my seizures/triggers for seizures. |
| **Progress in the past year:** | What has my seizure status for the past year been as compared with the year prior? |
| **As of the date this plan was signed, I have seizures about:** | [ ]  More than once a week | [ ]  More than once a month | [ ]  A few times a year, but not monthly. | [ ]  My last seizure was over a year ago | [ ]  My last seizure was over 3 years ago |
| **When I have a seizure, this is what usually happens:** | [ ]  I shake violently all over or in parts of my body. Indicate which areas of the body[ ]  My muscles get stiff or rigid.[ ]  My muscles get weak and I am not able to hold myself up.[ ]  I lose consciousness.[ ]  I stare off into space or become unresponsive.[ ]  I make an abnormal sound, I scream or yell.[ ]  I drool or foam at the mouth. [ ]  I lose control of my bladder function.[ ]  Other Describe any other things I do that happen to me when I have a seizure. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if:****🡪 I am having trouble breathing or stop breathing during or after a seizure.****🡪 I lose consciousness (become unresponsive).****🡪 I have a seizure that results in serious injury.****🡪 I choke or aspirate during a seizure.****🡪 I have a seizure lasting more than ## minutes.****🡪 I have more than ##seizure(s) in enter timeframe.****🡪 I have a seizure for the first time in more than 3 years.****🡪 Describe any additional instructions here** |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL** **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **My seizures usually last this long:** | Average length of seizures in seconds or minutes, whichever is shorter. | **Supporters should be aware that I am more likely to experience a seizure during these times and/or in these locations:** | [ ]  Any time of day[ ]  Morning[ ]  Afternoon[ ]  Before Bed[ ]  In any place[ ]  At home[ ]  Outside[ ]  In noisy, crowded places[ ]  Any other situation not listed. |
| **Supporters should be aware that some conditions and circumstances make it more likely that I will have a seizure:** | [ ]  I am tired.[ ]  I have not received my medication on time.[ ]  I have an illness or infection.[ ]  I have been outside in very hot or cold weather.[ ]  I have been in a place where there are flashing lights.[ ]  I am experiencing stress and anxiety.[ ]  Other Describe any other things that make seizures more likely, if not listed. |
| **This is how to support me during a seizure:** | [ ]  Make sure that I am in a safe place and all hazards have been removed.[ ]  Help me to a position where I am lying down on my side with my head positioned so that my airway is clear.[ ]  Cushion my head.[ ]  Remove any food or objects from my mouth.[ ]  Loosen my clothes, particularly around my neck.[ ]  Time the seizure.[ ]  Other Describe any other supports I need during a seizure, if not listed. |
| **When the seizure is over, here are the things my Supporters need to do:** | [ ]  Make sure I am clean and comfortable.[ ]  Help me to bed so that I can rest.[ ]  Notify the nurse.[ ]  Document the seizure on a seizure observation form.[ ]  Other Describe any other things that need to be done when my seizure is over, if not listed. |
| **Documentation:**  | Describe the things that staff should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to seizure disorder, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

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