**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

RN Typed Name and Agency

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

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