

Acute Seizure Action Plan (ASAP)

This ASAP can be used in conjunction with your longer Seizure Action Plan. Having this shortened version may be helpful in the event of a seizure.

Name: _____	Birth date: _____	Today's date: _____
Care partner phone numbers: _____	Provider name/facility: _____	Provider phone numbers: _____
_____	Telemedicine: _____	



Usual Seizure Pattern

Triggers: _____

Pattern of seizures: _____

What the seizures normally look like (Check all that apply)

<p>Head May Drop Loss of Muscle Control Stump or Fall Forward</p>	<p>Occurs Through the Entire Brain Blank Stare</p>	<p>Blinks Rapidly Bulb Their Eyes Can Be Confused With Daydreaming</p>	<p>Incontinence Stiff Body Epileptic Cry Back Arched</p>	<p>Jerky Movements Frothy Saliva Blinking Eyes</p>	<p>Occurs in Specific Lobe of the Brain Blank Stare</p>
<input type="checkbox"/> Atonic seizure (also called drop)	<input type="checkbox"/> Absence seizure (also called petit mal)	<input type="checkbox"/> Tonic seizure	<input type="checkbox"/> Clonic seizure	<input type="checkbox"/> Focal impaired awareness seizure (also called complex partial)	

Describe: _____

NOTES: _____

Care

Standard Care Needed

If this happens, _____ provide standard care

<p>Time the seizure</p> <p>NOTES: _____</p>	<p>STAY with person</p> <p>NOTES: _____</p>	<p>Keep person SAFE.</p> <p>NOTES: _____</p>	<p>Turn the person onto their SIDE</p> <p>NOTES: _____</p>	<p>Keep a record</p> <p>NOTES: _____</p>
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Provide Rescue Treatment

If this happens, _____ provide standard care (above) and rescue treatment

<p><input type="checkbox"/> Rectum</p>	<p><input type="checkbox"/> Nose</p>	<p><input type="checkbox"/> Mouth</p>	<p>Specific instructions: _____</p> <p><input type="checkbox"/> Other: _____</p>
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Call for Emergency Help

If any of these happen, _____ Get help now

<p><input type="checkbox"/> Seizure longer than _____ minutes</p>	<p><input type="checkbox"/> Unusual seizure</p>	<p><input type="checkbox"/> Injury/Blue lips</p>	<p><input type="checkbox"/> Other: _____</p>	<p>Healthcare provider name/phone number: _____</p>
NOTES: _____				

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____