Addressograph On every page

SEIZURE RECORD

PATIENT & CLINIC DETAILS

Date of Clinic :DD/MM/YYYY Clinic type delete:Epilepsy/General

Seen by :
Name & title

Height : …… Weight : …… Blood Pressure : ……

School :

PAST MEDICAL HISTORY

Early History :
Pregnancy / gestational age / birth history / birth weight / perinatal problems :

Medical History:

DEVELOPMENT/ EMOTIONAL-BEHAVIOURAL/SCHOOL

Early milestones *(insert age in months)*:

Sitting unsupported		Walking independently		1st words		sentences			

Developmental concerns? (Delay? Regression?) :

Emotional-behavioural concerns?

School (performance / progress / career plans/concerns):

DOCUMENTATION OF 1st ASSESSMENT FOR PAROXYSMAL EPISODE

Date of first episode leading to referral :
(give month if exact date is not available)

PAROXYSMAL EPISODE TYPE……. 1/2/3/4 of 1/2/3/4 ***(please delete as appropriate & add extra sheet for each additional type of episode & renumber pages)***

1. Witness :	*relationship to child:* *eye witness Y/N*
2. Symptoms & description of sequence of events : **Before** **During** *Onset* *Progression* *Ending* **After**	
3. Approximate duration	
4. Time of day/night/week	
5. Frequency	
6. Any provoking factors	
7. Description from home recording	

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ANTI EPILEPTIC MEDICATION

	Yes	No
Is the child already on any anti-epileptic medications? (*Details below)*	☐	☐
Has the child previously been on other anti-epileptic medication?	☐	☐
If yes to previous medication have you complete separate medication history chart?	☐	☐
Known contra-indications to any specific anti-epileptic medication?	☐	☐

Current anti-epileptic medication

Name	Dose	Date Started	Date of last change	Details/Adverse effects

Other drugs:

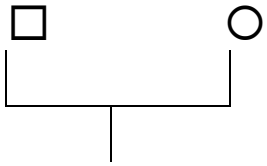
……

……

……

……

FAMILY HISTORY



Family history of epilepsy ☐ Yes ☐ No Details

Consanguinity ☐ Yes ☐ No Details

Any other significant conditions ☐ Yes ☐ No Details

EXAMINATION FINDINGS

General :

Head circumference :

Neurodevelopmental :

Dysmorphic features

Neurocutaneous markings

Speech& language

Behaviour

Gait

Handedness R/L *(please delete as appropriate)*

	Right	Left
Fundoscopy		
Visual fields		
Cranial Nerves		
Tone		
Reflexes		
Plantar response		

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INVESTIGATIONS & RESULTS

(please add additional sheets & renumber as necessary)

EEG : ☐ No ☐ Yes If yes, please give details :

Date	**wake/sleep/ telemetry etc**	**Finding**

ECG : ☐ No ☐ Yes If yes, please give details :

MRI : ☐ No ☐ Yes If yes, please give details :

Date	**Finding**

Metabolic / Genetic : ☐ No ☐ Yes If yes, please give details :

Date	**Finding**

Other Investigations (please give details) :

SUMMARY/DIFFERENTIAL DIAGNOSIS
Please attach copy of this page to child's care plan & any other documentation

EPILEPSY: Probable/possible/unlikely ***(please delete as applicable)***

IF EPILSPY UNLIKELY: alternative diagnosis & plan:

IF EPILEPSY LIKELY: probable seizure type(s)

1……..
2……..
3……..
4……...

IS IT POSSIBLE TO IDENTIFY EPILEPSY SYNDROME? YES/NO

EPILEPSY SYNDROME *if applicable*: …….

LIKELY AETIOLOGY:……

ASSOCIATED CONDITIONS

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PLAN FROM THIS VISIT

Home recording	☐ Yes	☐ No	☐ Already done
Standard EEG	☐ Yes	☐ No	☐ Already done
Sleep EEG	☐ Yes	☐ No	☐ Already done
CT / **MRI** (see below)	☐ Yes	☐ No	☐ Already done
ECG	☐ Yes	☐ No	☐ Already done

Other

EMERGENCY PLAN

	Yes	No
Has this child been prescribed rescue medication (e.g. Buccal Midazolam)?	☐	☐

Details:

	Yes	No
Does this child have a written emergency plan?	☐	☐
Does this child have a general care plan?	☐	☐

MEDICATION STARTED / ADJUSTED FOLLOWING THIS VISIT:

Name	Dose	List side effects discussed

INFORMATION

Medication alteration chart given? ☐ Yes ☐ No ☐ Alternative/NA

Information leaflet given? ☐ Yes ☐ No

If yes please specify
1)
2)

Information checklist completed? ☐ Yes ☐ No ☐ Not applicable

If no, please specify why not
……

Copy of your letter to parents? ☐ Yes ☐ No ☐ Not applicable

Contact details of health professional given? (e.g. epilepsy specialist nurse) ☐ Yes ☐ No ☐ Not applicable

If yes, please specify
1)Name:
Contact details:
2)Name:
Contact details:

FOLLOW UP

- When?
- Who by?

YOUR DETAILS

Signature : …… Date : ……

Print Name : …… Time : ……
(use 24hr clock)

Designation : …… Bleep Nº : ……