

# 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</p> <p>Loss of Muscle Control</p> <p>Slump or Fall Forward</p>	<p>Occurs Through the Entire Brain</p> <p>Blank Stare</p>	<p>Blinkly Rapidly Roll Their Eyes</p> <p>Can Be Confused With Daydreaming</p>	<p>Stiff Body</p> <p>Incontinence</p> <p>Back Arched</p> <p>Epileptic Cry</p>	<p>Jerky Movements</p>	<p>Frothy Saliva</p> <p>Blinking Eyes</p>	<p>Occurs in Specific Lobe of the Brain</p> <p>Blank Stare</p>	Describe: _____
<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)			

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,

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

### Healthcare Provider Authorization

Signature: \_\_\_\_\_ Provider Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_ For use from: \_\_\_\_\_ to: \_\_\_\_\_