

# SEIZURE REPORT

Name: \_\_\_\_\_ Date of seizure: \_\_\_\_\_

Time seizure began: \_\_\_\_\_ Duration: \_\_\_\_\_  Estimate  Actual

Observations prior to seizure: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Describe seizure in detail: \_\_\_\_\_

\_\_\_\_\_

**PHYSICAL SIGNS:**

Loss of bowel control?  Yes  No

Loss of bladder control?  Yes  No

Describe their breathing: \_\_\_\_\_

Skin color: \_\_\_\_\_

Conscious during seizure:  Yes  No

Responsive during seizure:  Yes  No

Comments: \_\_\_\_\_

Responsiveness and behaviour after seizure (e.g. to name, surroundings, memory of seizure, activities): \_\_\_\_\_

\_\_\_\_\_

Medical attention required:  Yes  No Time & Date \_\_\_\_\_

Concerns/comments \_\_\_\_\_

\_\_\_\_\_

People involved: \_\_\_\_\_

(Note: If seizure activity is unusual or requires medical attention, contact direct supervisor)

People contacted (e.g. Doctor, Supervisor, Guardian, etc.)

NAME	TIME	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recorded by: \_\_\_\_\_ Date: \_\_\_\_\_

Team Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

Binder(s):	Adult Services, Family Support Services					Page:	1 of 1
Section(s):	Medical	R	01-06-21	R/R	April 7, 2005	R/R	Jun 13/12
Program Area(s):	Adult Disability, Family Support Disability	R	Feb 7/18				