SEIZURE REPORT

***Please print clearly**

Individual Name:		Region:	DOB:
Date of seizure:	Time of seizure: ☐am ☐pm	Duration of Seizure:	minutes seconds
Location of seizure:			
Name of agency providing services at the time of seizure:			

What was the individual doing prior to the onset of the seizure?

Was the seizure "typical" for this individual? ☐ Yes ☐ No ☐ Unknown

Check All That Apply:

Mental State:	**Color:**	**Eyes:**	**Mouth:**
☐ Unchanged	☐ Very red/ flushed	☐ Turned right	☐ Drooled/ salivated
☐ Vacant	☐ Pale	☐ Turned left	☐ Chewing motion
☐ Unconscious	☐ Bluish	☐ Rolled up	☐ Swallowed
☐ Unresponsive to directions	☐ Bluish- mouth only	☐ Stared straight ahead	☐ Smacked lips
☐ Other:	☐ Other:	☐ Blinking/ fluttering	☐ Other:
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Movement/ Jerking:	**Muscle Tone:**	**Incontinent:**	**Breathing:**
☐ Whole body	**Rigid** **Limp**	☐ Bladder	☐ Became noisy
☐ Right arm	☐ ☐ Whole body	☐ Bowel	☐ Stopped breathing
☐ Left arm	☐ ☐ Right arm	**Voice:**	☐ How long? _____
☐ Right leg	☐ ☐ Left arm	☐ Cried out	☐ Other:
☐ Left leg	☐ ☐ Right leg	☐ Continuous cry	
☐ Jack knifed	☐ ☐ Left leg	☐ Talked	
☐ Repetitive	☐ ☐ Fell down	☐ Other:	
☐ Purposeful movement	☐ Other:		
☐ Other:			

After Seizure: ☐ Awake ☐ Sleepy ☐ Confused ☐ Unable to arouse ☐ Other: _____

Additional Comments (including any PRN medications given):

Printed Name:	Title	
Signature of Reporter	Date	Time

**Please note that it is up to the discretion of the team, including the Nurse, to determine the method of documentation for seizures.*