

**Full Life
Seizure Report**

Name: _____ Date: _____ Time: _____ a.m./p.m.

Where seizure occurred: _____

Check where appropriate; comment if necessary.

What was the individual doing at the time the seizure began? _____

Before seizure: Usual self Drowsy/tired Angry/excited
 Confused Sleeping _____

Mouth Movements: Lip Smacking Chewing Sucking

Comments: _____

During Seizure:

At first did he/she let out a cry? _____ Did the seizure begin in one particular place? Where and which side? (corner of mouth, left hand, etc.)

Face: Color

- Pale
- Cyanotic (blue)
- Red
- Unchanged

Eyes:

- Twitching
- Rolled back
- Turned to side
- Right
- Left
- Moving from side to side

Pupils:

- Small
- Reactive to light

Mouth:

- Lip smacking
- Chewing
- Swallowing
- Tongue biting
- Drooling
- Foaming

Body:

- Sudden loss of tone
- Movement started:
- Right arm
- Left arm
- Right leg
- Left leg
- Wild aimless movement
- Was the individual:

___ Unreactive to light
Difference in pupils:
___ Yes
___ No

___ Stiff
___ Relaxed
___ Writhing
___ Dazed
___ Tremulous
___ Convulsing
___ Fighting
___ Fainted
___ Acting Strangely

Consciousness:

___ Blank expression
Duration: ___ minutes
___ Loss of consciousness
Duration: ___ minutes

Describe: _____

Respiration:

___ Unchanged
___ Rapid
___ Irregular
___ Stopped

___ Did individual scream, cry, talk?
or make other sounds during seizure?
Describe: _____

How long? ___ minutes

How long did seizure last?
___ seconds and/or ___ minutes

Incontinent:

___ Bowel
___ Bladder

After Seizure:

___ Usual self
___ Dazed or confused
Duration: ___ min. ___ hr.
___ Sleepy
Duration: ___ min. ___ hr.

___ Slow to respond
Duration ___ min. ___ hr.
___ Excited
___ Crying
___ Headache

Injury (describe):

Comments:

Direct Support Worker signature: _____

Reviewed by: (RN/QMRP): _____