St. Clair County Community Mental Health Authority

Report of Seizure

Individual _____ Date: _____

Case #: _____ Time: _____ Am/Pm

Location of seizure (e.g., school, workshop, home, etc.): _____

What was individual doing before seizure? _____

Prior to seizure was Individual: ☐ Alert ☐ Drowsy ☐ Sleeping ☐ Other: _____

How long did seizure last?_____ (Do not include post-seizure sleep.)

Did individual experience a "warning"? If so, describe: _____

_____

NUMBER THE EVENTS YOU HAVE SEEN **IN ORDER OF THEIR APPEARANCE** DURING THE SEIZURE:

Stared_____ Cried out _____

Fell_____ Lost consciousness _____

Unresponsive _____ Impaired speech _____

Eyes turned: Left_____ or Right _____

Head turned: Left _____ or Right _____

Picking movements _____

Repetitive lip smacking, chewing or swallowing _____

Stiffening: One side only (left_____ or right_____); both sides _____

Jerking: One side only (left_____ or right_____); both sides _____

Confusion or disorientation _____ (specify duration_____)

OTHER SYMPTOMS: (Check if present)

☐ Drooling ☐ Loss of bladder control ☐ Loss of bowel control

☐ Turned blue ☐ Tongue bitten ☐ Other (describe): _____

☐ Vomiting

MEDICATIONS GIVEN (i.e., Valium): _____

WHAT WAS BEHAVIOR AFTER THE SEIZURE? (Check if present)

☐ Disoriented or confused (following motor seizure); length of time:

Complained of: ☐ Headache ☐ Weakness ☐ Body Aches ☐ Nauseated

☐ Vomited

☐ Other: _____

☐ Slept _____ How long:_____

DID INDIVIDUAL SUSTAIN ANY INJURIES AS A RESULT OF SEIZURE? ☐ Yes ☐ No

If yes, describe: _____

TRANSPORTED TO EMERGENCY ROOM:_____ HOSPITAL:_____

Observed by:_____ Self-Reported: _____

Reported by: _____

Original: CMH

CC: Home
Physician

Health-Medical Form: #04-0047
Reviewed Date: 3/1/2023
Policy Ref: #04-002-0025
EHR: Health Services, Health Information Documents, Seizures Note: (Report of seizure)