

## SEIZURE OBSERVATION REPORT

Individual:		Name(s) of Observing Staff:			
ID # :					
Living Unit:		Location of the Individual when Seizure Occurred:			
<b>Date and Time Seizure Started or Discovered:</b>		@ <input type="checkbox"/> am <input type="checkbox"/> pm			
<b>Activity Before the Seizure:</b>					
Check all that describe your observations of the individual right before the seizure started:		<input type="checkbox"/> Alert	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Other (describe):	
		<input type="checkbox"/> Drowsy	<input type="checkbox"/> Confused		
		<input type="checkbox"/> Sleeping	<input type="checkbox"/> Anxious		
		<input type="checkbox"/> Calm			
Describe what the individual was doing before the seizure occurred (what activity and what behavior):					
Did the individual experience a "warning sign" or aura before the seizure started? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known					
If yes, describe the warning sign or aura:					
Check all that describe the environment that the individual was in right before the seizure started:		<input type="checkbox"/> Noisy	<input type="checkbox"/> Flashing lights	<input type="checkbox"/> Other (describe):	
		<input type="checkbox"/> Crowded	<input type="checkbox"/> Hot		
Did you see the beginning of the seizure?		<input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, what did the start of the seizure look like?					
<b>Activity During the Seizure:</b>					
<b>Number</b> in the order in which they occurred during the seizure. Leave blank if they did NOT occur. If more than one occurred at the same time, give them the same number:	<input type="checkbox"/> Lost consciousness	<input type="checkbox"/> Fell	<b>Stiffness</b>		<b>Jerking</b>
	<input type="checkbox"/> Change in color	<input type="checkbox"/> Stared	<input type="checkbox"/> R-arm	<input type="checkbox"/> R-arm	
	<input type="checkbox"/> Bit tongue	<input type="checkbox"/> Incontinent	<input type="checkbox"/> L-arm	<input type="checkbox"/> L-arm	
	<input type="checkbox"/> Impaired speech	<input type="checkbox"/> Lip smack	<input type="checkbox"/> R-leg	<input type="checkbox"/> R-leg	
	<input type="checkbox"/> Drooling	<input type="checkbox"/> Eyes rolled	<input type="checkbox"/> L-leg	<input type="checkbox"/> L-leg	
<input type="checkbox"/> Blinking eyes	<input type="checkbox"/> Vomited	<input type="checkbox"/> Body arch	<input type="checkbox"/> R-face		
<input type="checkbox"/> Froth from nose or mouth	<input type="checkbox"/> Cried out	<input type="checkbox"/> Eyes to Rt	<input type="checkbox"/> L-face		
<input type="checkbox"/> Eyes to Lt	<input type="checkbox"/> All				
Other activity – specify what was seen and in what sequence:					
<b>Date and Time Seizure Ended:</b>		@ <input type="checkbox"/> am <input type="checkbox"/> pm			
Length of Seizure:					
<b>Activity After Seizure:</b>					
Check all that describe your observations of the individual after the seizure ended:		<input type="checkbox"/> Confusion	<input type="checkbox"/> Nausea	<input type="checkbox"/> Drowsy	<input type="checkbox"/> Resumed activity
		<input type="checkbox"/> Weak	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Agitated	<input type="checkbox"/> Slept: How long? _____
		<input type="checkbox"/> Body ache	<input type="checkbox"/> Headache	<input type="checkbox"/> Combative	<input type="checkbox"/> Injury
		<input type="checkbox"/> Other (describe):			
Additional Comments (any information that is clinically relevant):					
Signature and Title of Staff Completing Report _____				Date _____	Time _____

**Stamp Plate**

