

This Seizure Activity Observation Tool should be used when staff have been asked to document information about a person’s epilepsy and/or seizure activity by their General Practitioner, Neurologist or specialist and has been designed to record information about each seizure observed.

The tool should also be used where a person is new to Life Without Barriers and their seizure pattern and impact are unknown and need to be assessed.

The completed Observation Tool must be provided to the person’s doctor for review.

Name:		CIRTS:	
Address:		Date:	

Seizure period			
Time seizure started: (24 hr time)		Time seizure finished: (24 hr time)	

Before the seizure started:	
Was there any change in the person’s mood or behaviour?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Did the person complain of headaches or tiredness?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Did the person appear listless, restless, depressed or hyperactive?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Did anything happen to excite the person?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Did the person complain of vision, hearing or taste sensations?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Was the person nauseous?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)

<p>Did the person become aggressive, fearful, anxious or withdrawn?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)</p>
<p>Was the room temperature / environmental temperature high?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)</p>
<p>Please specify any other significant behaviour or factors:</p>	
<p>During the Seizure</p>	
<p>Was there any muscle movement at the beginning of the seizure?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below where the movement was located e.g. limbs, face, legs, all over)</p>
<p>What was the person's skin colour during the seizure?</p>	
<p>Did the person's skin colour change during the seizure? e.g. lips, nailbeds, overall colour</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)</p>
<p>Did the person appear to stop breathing during the seizure?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe how long before they regained normal breathing)</p>
<p>If already standing, did the person crumple to the ground or 'fall like a log'?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)</p>
<p>Did the person become incontinent of urine or faeces?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)</p>

After the Seizure	
Did the person lose consciousness?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If they lost consciousness, how long did they take to recover consciousness?	
Was PRN Medication given e.g. Midazolam	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below)
Was the person injured?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (if Yes, describe below and ensure the event is recorded into iSight)
If the person was injured, list below any strategies that could have prevented the injury	

Further Criteria to be observed (Criteria to be completed by Doctor only)			
Details of Health Professional reviewing Observation Tool			
Name:		Profession:	
Contact No:		Date tool provided:	

Details of Staff Member completing this Observation Tool			
Name:		Position:	
Signature:		Date:	

Upload to CIRTS as follows:

Plans & Assessments > New Plan > Plan name – [select from drop down] [relevant]
 Management Plan > relevant dates > Add New Attachment > Epilepsy Seizure Observation
 Recording Chart SURNAME, First Name. YYYY.MM.DD