

SEIZURE

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Recurrence Duration: _____ Activity at onset: _____

History:

Recent trauma High fever Substance abuse Psychiatric Seizures Diabetes Heat exposure

Past / current medication: _____

Time last seizure medication taken: _____ AM/PM Last medication level: _____ Results: _____

Associated symptoms:

Incontinence of bladder Incontinence of bowel Injuries

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ O₂ sats. _____

Respiration	Lung Sounds	Skin	LOC	Neurologic	Appearance
<input type="checkbox"/> Even	<input type="checkbox"/> Clear	<input type="checkbox"/> Warm	<input type="checkbox"/> Awake	<input type="checkbox"/> Gait steady	<input type="checkbox"/> No distress
<input type="checkbox"/> Uneven	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Pink	<input type="checkbox"/> Alert	<input type="checkbox"/> Gait unsteady	<input type="checkbox"/> Mild distress
<input type="checkbox"/> Labored	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Cool	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Grips equal	<input type="checkbox"/> Moderate distress
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Diminished	<input type="checkbox"/> Pale	<input type="checkbox"/> Confused	<input type="checkbox"/> Grips unequal	<input type="checkbox"/> Severe distress
<input type="checkbox"/> Shallow	<input type="checkbox"/> Rales	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Speech normal	
<input type="checkbox"/> Deep		<input type="checkbox"/> Mottled	<input type="checkbox"/> Comatose	<input type="checkbox"/> Speech slurred	
<input type="checkbox"/> Rapid		<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Follows commands	<input type="checkbox"/> Pupils equal	
			<input type="checkbox"/> Unable to follow commands	<input type="checkbox"/> Pupils unequal	

Description of seizure: (If witness) _____

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/medication required)

NOTIFY MEDICAL PROVIDER IMMEDIATELY IN ALL CASES OF SEIZURES:

Seizure Emergency: Immediate Emergency Care and Ambulance Transfer to Hospital without Delay

Status epilepticus

Refer to Medical provider if:

Postictal state lasts longer than one hour.

Notify medical provider if new onset.

Emergency department notification time: _____ Transport time: _____

Medical Provider Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alteration in comfort and neurological status related to seizure

Plan: Nursing Intervention Routine: (check all that apply)

Check in assessment only for medical providers visit.

Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.

If offender actively having seizure activity, protect from injury and prevent aspiration

Do not force objects such as oral airway or tongue blade between closed jaws

Remain with offender, position on one side to help maintain airway and prevent aspiration

Loosen clothing, establish a quiet area (with security assistance) to reduce stimulation during postictal period, monitor offender during this time

Seizure activity generally lasts 2-3 minutes-use clock or watch to time activity

Education/Intervention: Instructed on medication compliance and use, factors that trigger seizures, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

DOC #