

SEIZURE REPORT

NAME: _____ PROGRAM: HCS
DOB: _____ RECORD NO.
TIME: _____ DATE: _____
PLACE OCCURRED: _____

WAS THERE A CRY? Yes ___ No ___
DID THE FACE CHANGE COLOR? Yes ___ No ___
DID THE CONSUMER FALL? Yes ___ No ___
DIRECTION OF FALL? BACKWARD? ___
FORWARD? ___
RIGHT? ___ LEFT? ___
DID THE HEAD TURN TO ONE SIDE? Yes ___ No ___
RIGHT ___ LEFT ___
WERE THE EYES OPEN? Yes ___ No ___
IF OPEN, WERE THEY TO ONE SIDE OR THE OTHER? RIGHT ___ LEFT ___
BACK ___
WERE THE ARMS AND LEGS STIFF? Yes ___ No ___
AFFECTED SIDE RIGHT ___ LEFT ___
DID THE FACE TWITCH OR JERK? Yes ___ No ___
AFFECTED SIDE-RIGHT ___ LEFT ___
DID THE ARMS TWITCH OR JERK? Yes ___ No ___
AFFECTED SIDE-RIGHT ___ LEFT ___
DID THE LEGS TWITCH OR JERK? Yes ___ No ___
AFFECTED SIDE-RIGHT ___ LEFT ___
WERE THE TWO SIDES EQUALLY AFFECTED? Yes ___ No ___
DID THE TWITCHING BEGIN IN ONE PART? Yes ___ No ___
WHICH PART? _____
DID THE PERSON SPEAK DURING THIS TIME? Yes ___ No ___
HOW LONG DID THE JERKING LAST? _____
WAS THE PERSON QUIET AFTER JERKING STOPPED? Yes ___ No ___
WAS THERE FROTH AT THE MOUTH? Yes ___ No ___
BLOOD STAINED? Yes ___ No ___
WAS THE TONGUE BITTEN? Yes ___ No ___
DID THEY URINATE? Yes ___ No ___
DID THE BOWELS MOVE? Yes ___ No ___
HOW LONG DID THE SEIZURE LAST? Yes ___ No ___
WAS OXYGEN USED? Yes ___ No ___
WAS THERE WEAKNESS IN ANY PART OF BODY
AFTER PERSON RECOVERED? Yes ___ No ___

PERSON WITNESSING SEIZURE SIGNATURE _____
DATE _____ TIME _____
NOTIFICATION OF NURSE? _____ CASE MANAGER? _____
911? _____ PARENT OR GUARDIAN? _____
WHICH HOSPITAL TRANSFERRED TO? _____