



Professional Nursing Services

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Seizure Documentation Form

CLIENTS NAME

DATE

NAME & TITLE OF PERSON COMPLETING FORM

When did the seizure start?

_____ AM _____ PM

When did the seizure end?

_____ AM _____ PM

Symptoms of the Seizure (Check all that apply)

What did you notice happening during the course of the seizure?

- Rapid jerking body movements
- Body limbs stiffened and shaking began
 - Right side of body only
 - Left side of body only
- Jerking of the face or limbs that lasted more than a second or two
- Client cried/squealed out
- Client made gurgling or grunting noises
- Client fell to ground, had a seizure, and injured self
- Client fell to ground, had a seizure, NO injury occurred
- Client had a loss of bladder control
- Client had a loss of bowel control
- Client had rapid eye movements
- Client cyanotic (looked bluish-grey in color)
- Client's body went limp
- Client was smacking lips
- Client walking/wandering
- Client had other repetitive movements
- Client looked like they were staring and unable to respond in a manner that made sense
- Client was picking at clothing
- Client lost consciousness (not aware what was going on)
- Client had shallow breathing
- Client stopped breathing

LIST OTHER SYMPTOMS NOTICED DURING THE SEIZURE

What was the client doing before the seizure happened? (If client was injured during the seizure, indicate type of injury sustained)

Did the client appear to be oriented after the seizure stopped? (Did the client know where they were and what was going on?)

If the client is not oriented within 5 minutes of having the seizure, how long did it take for them to become oriented? (Indicate if nurse notified, 911 called, guardian/caregiver notified, follow ER protocol + MD orders)

