California Correctional Health Care Services

Encounter Form: Seizures

Institution: _____

Name:_____ CDC#_____ DOB_____ Date/Time _____

Fill in the blanks and check all that apply

SUBJECTIVE:

Chief Complaint: _____

Time: _____ ❑ patient found ❑ of onset

Circumstances surrounding seizure:

Seizure activity: Started (time): _____ Ended (time): _____

❑ Info from witness (name; description of event): _____

_____

_____

❑ Info from patient: _____

_____

_____

_____

Pain: Scale of 0-10 (0=no pain 10=worst pain) _____

Area of pain: _____

What makes it better or worse? _____

History of: ❑ Missed seizure medication ❑ Head trauma ❑ ETOH abuse ❑ Diabetes

Current medications (including last dose taken) if patient is receiving anticonvulsant or diabetic medication: _____

_____

Chronic illnesses: _____

_____

Allergies: _____

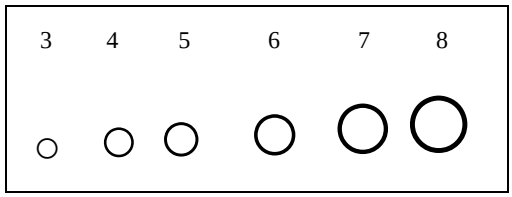
OBJECTIVE:

❑ ABCs present

Vital Signs

Time	BP	Pulse	Resp	O2 Sat.

Pupil Size



Time	Circle and describe
	PERL Abnormal _____
	PERL Abnormal _____
	PERL Abnormal _____
	PERL Abnormal _____

Glasgow Coma Scale (GCS)

Parameter	Finding	Score
Eye Opening	Spontaneously	4
	To speech	3
	To pain	2
	Do not open	1
Best Verbal Response	Oriented	5
	Confused	4
	Inappropriate speech	3
	Unintelligible speech	2
	No verbalization	1
Best Motor Response	Obeys command	6
	Localized pain	5
	Withdraws from pain	4
	Abnormal flexion	3
	Abnormal extension	2
	No motor response	1
Interpretation: best = 15; worst = 3		

Glasgow Coma Scale				
Time				
Eye Opening				
Best Verbal Response				
Best Motor Response				
Glasgow Coma Score				
Oriented to time, person, place, situation	Y N	Y N	Y N	Y N

Observe, describe, and document the following:

❑ Cyanosis ❑ Apnea ❑ Abnormal eye movements
❑ Lip smacking ❑ Swallowing ❑ Chewing
❑ Profuse salivation ❑ Tonic/clonic movements
❑ Injury to mouth or limbs ❑ Urinary incontinence
❑ Stool incontinence

Fingerstick blood glucose: (time/ results)_____

ASSESSMENT:

❑ Risk for injury related to/evidenced by: _____

_____

❑ Risk for aspiration related to/evidenced by:_____

_____

❑ Alteration in tissue perfusion, cerebral, related to/ evidenced by:_____

_____

_____

Signature / Title

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PLAN:

MD referral completed: (circle) NO / YES If yes:

❑ **STAT** (Status epilepticus) ❑ Urgent ❑ Routine

Physician called (name / time) _____

Physician responded (time) _____

ACUTE SEIZURE ACTIVITY

- ❑ Assess ABC (airway, breathing, and circulation). Use oral or nasopharyngeal airway if indicated.
- ❑ Loosen clothing around neck.
- ❑ Place patient in left lateral decubitus position to prevent aspiration. Suction any vomitus or excessive saliva from mouth.
- ❑ Place on pulse oximeter and administer supplemental oxygen at 2-6L/minute via nasal cannula to maintain oxygen saturation above 92%.
- ❑ Move potentially dangerous items away from the patient. Avoid restraining patient or forcing anything through clenched teeth.

Record the following:

- ❑ Duration of seizure activity;
- ❑ Type of seizure;
- ❑ Whether the patient lost consciousness and how long he remained unconscious;
- ❑ All behaviors observed during the seizure; and
- ❑ Level of consciousness after the seizure.

- ❑ Remain with the patient until vital signs are stable and seizure activity ends.
- ❑ Transfer the patient to the triage and treatment area.
- ❑ Venous blood sample drawn for blood glucose, AED drug level, CBC and chem. panel (specify) _____ _____
- ❑ Notify the physician.
- ❑ If signs of injury are present, call Medical Officer of the Day for further direction.

STATUS EPILEPTICUS

- ❑ Assess ABC (airway, breathing, and circulation). Use oral or nasopharyngeal airway if indicated.
- ❑ Loosen clothing around neck.
- ❑ Place patient in left lateral decubitus position to prevent aspiration. Suction any vomitus or excessive saliva from mouth.
- ❑ Place on pulse oximeter and administer supplemental oxygen at 2-6L/minute via nasal cannula to maintain oxygen saturation above 92%.
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Record the following:

- ❑ Duration of seizure activity_____
- ❑ Type of seizure_____
- ❑ Whether the patient lost consciousness and how long he remained unconscious_____
- ❑ All behaviors observed during the seizure _____
- ❑ Level of consciousness after the seizure_____

- ❑ Remain with the patient until vital signs are stable and seizure activity ends.
- ❑ Two IVs of Sodium Chloride Intravenous Solution (0.9%) at TKO started at (time) _____/_____ in (location) _____/_____ using (needle) ____/____

Administer:

- ❑ Lorazepam 4mg IV push over 2 minutes (give slowly not greater than 2mg per min) – wait 1 minute for response, then repeat if seizure continues. If unable to obtain IV access, administer Lorazapam 4mg IM.

1st Dose: (time started/site) _____

2nd Dose: (time started/site) _____

If hypoglycemic or blood glucose level not available, administer: FSBS: _____

- ❑ 50ml of 50% Dextrose IV push over 2 minutes started at (time) _____
- ❑ Thiamine 100 mg IV
  Fingerstick after medication: (time) _____

- ❑ Monitor respiration and pulse every five minutes until stable, then every 15 minutes.
- ❑ Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care as indicated.
- ❑ Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility.

EDUCATION:

- ❑ Assess patient's potential for understanding the health information to be provided.
- ❑ Provide patient education consistent with the assessment of the condition.
- ❑ Document the education provided and the patient's level of understanding on the emergency care flow sheet.

_____

Signature / Title

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- ❑ Refer patient to other resources as needed. Document all referrals on the emergency care flow sheet.
- ❑ Advise patient to utilize the urgent/emergent process to access medical care if symptoms recur.

Patient instructed in:

- ❑ Use of medication
- ❑ Use of alcohol and/or drugs
- ❑ Blood glucose monitoring
- ❑ Importance of keeping scheduled appointments
- ❑ Other: _____

_____

- ❑ Resubmit Health Care Service Request Form (CDC) 7362) if: seizure reoccurs, aura or loss of consciousness occurs; use of drugs or alcohol; missed medications; or _____

_____

- ❑ Education deferred due to patient condition

DISPOSITION

Time released: _____

- ❑ Condition on release: _____
- ❑ Returned to housing unit
- ❑ Housing reassignment to: _____
- ❑ Referred for follow-up
  - ❑ Physician clinic ❑ RN clinic

Referred to higher level of care: (specify) _____

_____

Person/time contacted: _____

- ❑ Records faxed to facility

Time/Mode of transfer: _____

ERV contacted (time) _____

ERV arrived (time) _____

Name of RN Protocol(s) used:_____

_____

_____

Signature / Title

1. Disability Code:	2. Accommodation:	3. Effective Communication:
☐ TABE score ≤ 4.0	☐ Additional time	☐ P/I asked questions
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☐ P/I summed information
☐ DPS ☐ DNH	☐ Louder ☐ Slower	**Please check one:**
☐ DNS ☐ DDP	☐ Basic ☐ Transcribe	☐ Not reached* ☐ Reached
☐ Not Applicable	☐ Other*	*See chrono/notes

4. Comments: _____