HOSPITAL ACTION PLAN

NAME OF PATIENT_____

Address_____

Phone #_____

1. Caregiver / Advocate Name_____
   Primary Phone #_____ Secondary Phone #_____
   Relationship to patient_____
2. Caregiver / Advocate Name_____
   Primary Phone #_____ Secondary Phone #_____
   Relationship to patient_____
3. Neurologist _____ Phone #_____
   Hospital Affiliation_____

Diagnosis_____

Type / Description of Seizure_____

Description of post-ictal state_____

Daily Medications / Dosages_____

_____

_____

Rescue Medication / Dosage_____

VNS or Other Device _____

Other Diagnoses _____

_____

Surgery / Date_____

Procedures / Date_____

Allergies_____

_____

*******_**If I am unable to make medical decisions please contact my advocate above prior to performing any non-emergent treatment.**_