Outpatient Episode Description Sheet

Directions

Before your appointment, describe the different types of seizure-like events your child has. If you were not the witness, talk with the person who saw the events first-hand to fill out the details below. Use whatever language your family uses to describe them, such as "the checking out type" or "the shaking all over type." If you are not sure, complete it as best as you can.

We will review this information with you at your child's appointment. If possible, send it in before your appointment and take videos of the events.

Child's Name: _____

Date of birth: _____

Date of my child's very first seizure-like event: _____

Event type 1: _____ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: _____

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: _____

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Other: _____
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event

To Learn More

- Neurology
  206-987-2078
- Ask your child's healthcare provider
- seattlechildrens.org

Free Interpreter Services

- In the hospital, ask your nurse.
- From outside the hospital, call the toll-free Family Interpreting Line, 1-866-583-1527. Tell the interpreter the name or extension you need.

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Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen during sleep (or when drowsy)
- ❑ Happen when awake
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Event type 2: _____ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: _____

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: _____

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Other: _____
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event

Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen at night
- ❑ Happen during the day
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Event type 3: _____ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: _____

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: _____

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Other: _____
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event

Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen at night
- ❑ Happen during the day
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Please send this completed form to:

Mail: Seattle Children's Neurology

Attn: First Seizure Clinic
4800 Sand Point Way NE, MB.7.420
Seattle, WA 98105

Fax: 206-987-2649 **Email:** firstseizure@seattlechildrens.org

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