

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Medical Record Number: [Insert MRN]

To Whom It May Concern,

This letter outlines the current antiepileptic medication treatment plan for the above-named patient, who is under my care for the management of [Insert Type of Epilepsy/Seizure Disorder].

1. Current Medications

- **Medication Name:** [Insert Drug Name]
- **Dosage:** [Insert mg]
- **Frequency:** [e.g., Twice daily]
- **Timing:** [e.g., 8:00 AM and 8:00 PM]

2. Emergency Rescue Medication

In the event of a prolonged seizure (lasting more than [Number] minutes) or a cluster of seizures, the following rescue medication should be administered:

- **Medication Name:** [Insert Rescue Drug Name]
- **Dose:** [Insert Dose]
- **Administration Route:** [e.g., Nasal, Buccal, Rectal]

3. Known Side Effects and Precautions

The patient may experience the following side effects: [Insert Side Effects]. If any of the following serious symptoms occur, seek medical attention immediately: [Insert Red Flag Symptoms].

4. Seizure First Aid

If a seizure occurs:

- Keep the patient calm and stay with them.
- Ensure the environment is safe and clear of sharp objects.
- Do not restrain the patient or place anything in their mouth.
- Time the duration of the seizure.

5. Physician Contact Information

Clinic Name: [Insert Clinic Name]

Physician Name: [Insert Physician Name]

Phone Number: [Insert Phone Number]
After-Hours Contact: [Insert After-Hours Info]

Sincerely,

[Physician Signature]
[Physician Name, Title]
[License Number]