Antiepileptic Medication Transition Log

Patient Name: _____

Date of Birth: _____

Physician Name: _____

Clinic Contact: _____

Transition Summary

Current Medication (Tapering Off): _____

New Medication (Titrating On): _____

Transition Start Date: _____

Estimated Completion Date: _____

Dosing Schedule

Week / Phase	Morning Dose	Evening Dose	Notes
Week 1			
Week 2			
Week 3			
Week 4			

Seizure and Side Effect Log

Date	Seizure Activity (Type/Duration)	Side Effects Observed	Mood/Behavior Changes

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Emergency Instructions

If a breakthrough seizure occurs: _____

Rescue Medication (if prescribed): _____

Contact doctor immediately if: _____

Patient/Guardian Signature: _____ Date: _____