Vagus Nerve Stimulation (VNS) Documentation Record

Individual Name: (Required)	**D.O.B:** (Required)
Diagnoses: (Required)	**Diet:** (Required)
Known Allergies: (Required)	
Month: (Required)	**Year:** (Required)

boundless
inspiring the potential of people

Date	Time	Staff Initials	Was 911/EMS Contacted? Y/N	Was Family Notified? Y/N	Length of Seizure	Number of Swipes	Description of Seizure	Other Observations

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Direct Support Staff (Print Name) Initials Direct Support Staff (Signature) Date

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