

VALPROATE - INFORMED CONSENT FOR MEDICATION

Medication Category: anticonvulsant, mood stabilizer	Medications: valproic acid (Depakene); valproate (Depakote)
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Prescribed medication: _____ anticipated dosage range: _____

About your medicine: Anticonvulsant medications are generally used for the treatment of epilepsy and seizures. However, some anticonvulsants have been found useful in the treatment of some psychiatric disorders including mania, depression and schizophrenia. They act as mood stabilizers, decreasing mood swings. In some cases they help people to gain control over their impulsive and aggressive behaviors. They can also increase the effectiveness of other medications, especially antidepressant medications. The anticonvulsants are often given in combination with an antipsychotic medication, and antidepressant medication, or lithium.

Side Effects: Every medication is capable of producing side effects. Many people who take anticonvulsant medications experience no, or minor side effects. The frequency and severity of side effects depend on many factors including dose, duration of therapy and individual susceptibility. Possible side effects include:

More Common: nausea, upset stomach, diarrhea, tremors, and sedation.

Less Common: skin rashes, weight gain, and hair loss.

Precautions: **Serious liver disease** has been reported with Valproate and valproic acid although this seems rare in adults. Anyone taking these medications that experiences loss of appetite, jaundice nausea or lethargy should contact their physician and have liver function tests performed. Problems with making blood platelets is rare but has also been reported, and anyone who experiences easy bruising or bleeding should have an immediate platelet count. **Caution should be used as this medication may impair your ability to operate automobiles or other potentially dangerous machines, coordination and judgment.**

Birth defects have been associated with this medication taken by mothers during the first three months of pregnancy.

By my signature below, I give consent for the above-named medication to be administered and for a change of medication within this medication category. My signature also indicates that I am aware of, have read and discussed the reasons for the use of this medication, and its potential risks and benefits.

Client Signature: _____ Date Signed _____

Witness Signature: _____ Date Signed _____

Pathway Clinic/Wisconsin Eating Disorder Specialists