MEDICAL ALERT CARD

I, ________________________________, have **Restless Legs Syndrome ("RLS")**, a chronic condition primarily causing extreme discomfort in my legs (sometimes arms & trunk) and causing an irresistible urge to move. My symptoms increase when at rest or inactive, and typically decrease by voluntary movements of my affected limb(s).

ATTENTION: Healthcare Providers

- ✓ Be alert for **symptoms** described above.
- ✓ Continue patient's **treatment** of choice **or** administer RLS medications prescribed by patient's physician to control symptoms.
- ✓ Avoid **restraints**.
- ✓ Administer dopamine-antagonist agents with **extreme caution**.

The following medications (dopamine-antagonist agents & others) may cause significant worsening of RLS.

Administer with EXTREME CAUTION:

- Anti-nauseates—Benadryl, Antivert (meclizine), Atarax, Bonine, Compazine, Phenergan, Thorazine, Tigan, Trilaton, Vistaril, Reglan; S***afe alternatives***: Kytril, Zofran, Transderm Scop patch for sea sickness.
- Anti-psychotics—Haldol, Loxitane, Mellaril, Moban, Navane, Prolixin, Risperdal, Serentil, Stelazine, Thorazine, Vesperin
- Atypical Neuroleptics—approach with ***caution***: Clozaril, Risperdal, Seroquel, Zyprexa. *suggested alternative:* **Abilify (possibly)**
- Anti-depressants—ALL can cause RLS worsening; ***Safe alternatives:*** trazodone, Serzone , Wellbutrin, desipramine (possibly)
- Anti-histamines—BEWARE OF ALL sedating antihistamines, especially Benadryl & OTC/Rx combination cold/sinus/cough medications; Actifed, Comtrex, Contact, Dimetapp, Triaminic, Theraflu, Vicks cough syrup, Tylenol PM, Excedrin PM, Bayer PM, Sominex, Unisom. **Safe alternatives:** Claritin, Alavert, Clarinex, Allegra, Zyrtec (usually)

MEDICATION RECORD

Name_____ ____

Address____

______________________________Ph__________________

Doctor________________________ Ph__________________

Pharmacist____________________Ph__________________

I am being treated for:

1.______________________ 2.________________________

3.______________________ 4.________________________

Medication Allergy/Sensitivity	*Reaction*	*Date*
____________________	_____________________	_________
____________________	_____________________	_________

Emerg Contact:______________________ Ph_____________

NON-PRESCRIPTION *medications I take regularly or as needed*:

Start Date	Medication Name & Strength	Directions
_________	____________________________	____________
_________	____________________________	____________
_________	____________________________	____________
_________	____________________________	____________
_________	____________________________	____________
_________	____________________________	____________

PRESCRIPTION *medications I take regularly or as needed*:

Start Date	Medication Name & Strength	Directions
_________	____________________________	____________
_________	____________________________	____________
_________	____________________________	____________