Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

STIMULANT MEDICATION TREATMENT INFORMED CONSENT FORM

Patient education and treatment authorization

Patient Information

Patient name: _____ Date of birth: _____

Prescriber: Patrick Masiasia, APRN, CNP, PMHNP-BC Diagnosis: _____

Medication: _____ Starting dose: _____

Preferred pharmacy (one pharmacy only): _____

1. Purpose and Benefits of Treatment

Stimulant medications may be prescribed for ADHD and other clinically appropriate conditions. Potential benefits include improved attention, concentration, impulse control, organization, and daily functioning. Individual responses vary, and benefits are not guaranteed.

2. Potential Risks and Side Effects

Common side effects may include:

- Decreased appetite and weight loss
- Insomnia or difficulty sleeping
- Dry mouth, headache, and nausea
- Irritability, anxiety, or restlessness
- Increased heart rate and blood pressure

3. Cardiovascular and Psychiatric Risks

Stimulants may increase blood pressure and heart rate. Rare but serious complications include cardiac arrhythmias, heart attack, stroke, and sudden cardiac events, particularly in individuals with underlying cardiovascular disease. Other potential risks include worsening anxiety, agitation, mania, psychosis, or mood instability.

4. Misuse, Dependence, and Addiction

Stimulant medications have potential for misuse, abuse, physical dependence, and addiction. Taking more than prescribed or sharing medication is unsafe and prohibited. Patients must report concerns about cravings, escalating doses, or difficulty controlling medication use.

5. Health History I Have Disclosed

I have told my prescriber if I have, or have ever had, any of the following (check all that apply, or check None):

☐ Heart disease, heart rhythm problems, or sudden cardiac death in my family ☐ High blood pressure ☐ Stroke

☐ Glaucoma ☐ Overactive thyroid ☐ Seizures ☐ Tics or Tourette syndrome

☐ Bipolar disorder, mania, or psychosis ☐ Substance use disorder or past misuse of medications

☐ Use of an MAOI antidepressant in the past 14 days ☐ Pregnant, planning pregnancy, or breastfeeding ☐ None of these

6. Safe Medication Use and Storage

I agree to:

- Take medication exactly as prescribed
- Never share or sell prescribed medication
- Store medication securely, preferably locked, and away from children and others
- Avoid unauthorized dose adjustments
- Use one pharmacy for stimulant prescriptions unless I tell my prescriber in advance
- Inform my prescriber about other medications and substances, including alcohol and cannabis
- Report adverse effects and medication-related concerns promptly
- Use caution with driving or operating machinery until I know how the medication affects me

7. Controlled-Substance Prescribing Expectations

I understand that stimulant medications are controlled substances. Prescriptions are subject to applicable federal and Minnesota laws and clinic policies. Early refills, replacement prescriptions for lost, stolen, or damaged medication, and dose increases are not guaranteed. I understand that federal and state rules about prescribing controlled substances by telehealth, including any requirement for an in-person evaluation, may change, and that my prescriber may require an in-person visit to continue prescribing.

8. Prescription Monitoring and Follow-Up

I understand that my prescriber may review the Minnesota Prescription Monitoring Program (PMP), request medication counts or toxicology testing when clinically indicated, and monitor blood pressure, pulse, weight, appetite, sleep, and treatment response. I agree to attend scheduled follow-up appointments and participate in recommended monitoring.

9. Emergency Warning Signs

I will seek emergency medical attention for:

- Chest pain or severe shortness of breath
- Fainting or seizure
- Severe or irregular heartbeat
- Symptoms of stroke
- Severe allergic reactions
- Severe confusion, hallucinations, or dangerous behavioral changes

For suspected overdose, call 911 or Poison Control at 1-800-222-1222.

10. Patient Acknowledgment and Consent

I acknowledge that the benefits, risks, alternatives, and responsibilities associated with stimulant medication treatment have been explained to me. I have had an opportunity to ask questions and receive answers. I understand that I may decline or withdraw consent and discuss alternative treatments with my prescriber. This consent does not guarantee a prescription, and I understand that a separate controlled-substance agreement may be required.

Patient signature: _____ Date: _____

Prescriber signature: _____ Date: _____

Legal representative signature (only if the patient has a court-appointed guardian or conservator):

_____

This form supplements, but does not replace, medication-specific counseling or a separate controlled-substance agreement.