

STIMULANTS - INFORMED CONSENT FOR MEDICATION

<u>Medication Category:</u> Stimulants	Medications in this Category: methylphenidate (Ritalin); dextroamphetamine (Dexedrine)
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Prescribed medication (or equivalent) _____ anticipated dosage range _____

About your medicine: Stimulants are used in the treatment of Attention Deficit Hyperactivity Disorder to decrease distractibility, hyperactivity, impulsivity and emotional instability and to increase attention span. This medication can also be used to augment antidepressant effectiveness (not FDA approved for this indication). This medication should be used as part of a treatment program which may include psychological, social and educational components.

Side Effects: Every medication is capable of producing side effects. Many people who take stimulants 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: insomnia, decreased appetite, nervousness, nausea, abdominal pain, headache, elevations of heart rate and blood pressure, dizziness, and heart palpitations.

Less Common: there have been rare reports of stimulants causing Tourette's syndrome, which is a chronic motor and vocal tic disorder. These medications can cause hypersensitivity (allergic) reactions including rash, hives, fever, etc. If this should occur, medication should be discontinued and your doctor notified. In extremely agitated patients this medication needs to be used with caution as it can worsen this condition. On occasion the medications can adversely affect mood state.

Precautions: These medications should not be used in patients with high blood pressure, hyperthyroidism, glaucoma, extremely agitated states or history of drug abuse. Let your doctor know if you are taking other medications in combination with stimulants. Medications that increase heart rate or blood pressure should be avoided. Nursing mothers and pregnant women should not take the medication.

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