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Ste 100 - 1696
Newtown Square, PA 19073
484-326-5392 (P), 304-853-5130 (F)
<https://stfrancisxavierpsychiatric.com/>

Patient Information

Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email: _____

Medical History

Please indicate any existing medical conditions and provide details regarding your cardiac history.

- Cardiomyopathy
- Arrhythmias
- Hypertension
- Heart Valve Disorders
- Coronary Artery Disease
- Other

Details:

Medication Information

Are you currently taking any medications for your cardiac condition? If yes, please list:

Stimulant Prescription

I, _____, understand that I have a history of cardiac issues, specifically cardiomyopathy, and that taking a stimulant medication, may have implications for my cardiovascular health. I acknowledge that the prescribing clinician at St Francis Xavier Psychiatric

Services has discussed the risks and benefits of stimulant treatment with me, including the potential exacerbation of cardiac symptoms or complications.

I understand that it is important to monitor my cardiac health closely while taking stimulants and I agree to comply with all recommended medical evaluations, including regular cardiac assessments with cardiologists and follow-up appointments. I understand that I should promptly report any new or worsening symptoms related to my cardiac health to my healthcare provider.

I acknowledge that I have been provided with information about alternative treatment options for managing my ADHD symptoms and that I have chosen to proceed with a stimulant despite the potential risks to my cardiac health. I understand that this decision is made in consultation with my healthcare provider and is based on an assessment of my individual medical history and treatment goals.

I hereby release St Francis Xavier Psychiatric Services, LLC, and its healthcare providers from any liability related to the use of a stimulant in the context of my cardiac history. I understand the potential risks involved and agree to assume responsibility for my health and well-being while undergoing treatment with a stimulant.

Patient's signature

Date

Physician's signature

Date

Please retain a copy of this waiver for your records. If you have any questions or concerns, please do not hesitate to contact us at St Francis Xavier Psychiatric Services, LLC.