im HEALTH

372 West Lancaster Ave
Wayne, PA 19087

Provider-Patient Agreement for Stimulant Medications

I understand that I have attention deficit hyperactivity disorder (ADHD, ADD) that currently requires the use of controlled medication to increase my function. The risks, side effects and benefits of the medication have been discussed with me in detail.

I, _____understand that I must comply with and adhere to the following conditions in order to receive my controlled medications.

_____I will obtain all my controlled substances from the provider whose signature appears below or, during his or her extended absence, by the covering provider.

_____I will obtain all my controlled medication from one pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy I select is: _____ I understand that if my prescription is out of stock at my preferred pharmacy, it is my responsibility to call other pharmacies and once found I will notify IM Health where to send my prescription.

_____The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

_____ I understand that at any point during the treatment, the prescribing physician or nurse practitioner may request a random drug screen.

_____I agree to use my medication only as directed. I will not increase, decrease, or abruptly stop taking my medication without my provider's knowledge and permission.

_____I understand that it is my responsibility to schedule a more urgent appointment if I begin to experience any problems associated with my controlled medications, or if other medical conditions that may be affected by my medication arise.

_____I understand that my provider may choose to discontinue my controlled medication if he/she believes that my ADHD or ADD is not improving, my medication usage is escalating, my functional ability is not increasing, or if I begin to experience unacceptable side effects. In this event, my provider will refer me to a licensed mental health practitioner.

_____I am aware of the risks of concurrent alcohol use. I will not use illegal substances while taking my controlled medication. I will not sell or share my controlled medications, allow others to use my medication, alter my medication prescriptions, or use my medications in any unintended ways.

Requesting Refills and Follow-up

_____I agree to schedule an appointment no longer than every 90 days or as directed by my provider for the purpose of renewing my prescriptions and assessing my progress.

_____ I understand that my prescription refill request will be made within three business days.

_____I understand that early refills will generally not be given, though arrangements for travel can be made with my provider.

_____ Medications may not be replaced if lost, destroyed/damaged, or stolen. Stolen medications with a completed police report are an exception. My provider may consider replacing lost, misplaced or stolen controlled medications only at an appointment.

_____I will keep my medications safely away from children.

_____I will notify my provider if I intend on becoming pregnant or become pregnant.

Notice of Risk

The use of controlled substances may be associated with certain risk such as, but not limited to:

Central nervous system: jitteriness, sleep disturbance, tension, psychomotor restlessness, and emotional lability.

Cardiovascular: blood pressure elevation, tachycardia, arrhythmia, palpitations.

Gastrointestinal: weight loss, poor growth, anorexia.

Dermatological: itching and rash.

Endocrine and metabolic: hot flashes, increased thirst, weight loss.

Urinary: erectile dysfunction.

Drug Interactions with or altering the effect of other medications cannot be reliably predicted.

Addiction (abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a nonmedical supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.

Allergic reactions are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

I understand the risks and benefits of taking this stimulant and agree to the terms above.

Patient / Guardian Name: _____ DOB:_____

Patient / Guardian Signature: _____ Date_____

Provider Signature: _____ Date_____