Boulder Community Health

***Clinic Name*:_____*Provider*:_____**

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 physician whose signature appears below or, during his or her extended absence, by the covering physician.

_____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: _____

_____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 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 I can only receive controlled medication refills at scheduled appointments or as discussed with my provider. I agree to schedule an appointment no longer than every 120 days or as directed by my provider for the purpose of renewing my prescriptions and assessing my progress.

_____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 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 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. I will keep my medications safely away from children.

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

_____Absolutely no use of alcohol or illegal substances will occur while driving.

_____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.

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 non-medically 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.

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Failure to adhere to the above policies may result in cessation of your controlled medicine prescribing by this provider or referral for further specialty assessment.

Patient / Guardian Name:_____ DOB:_____

Patient / Guardian Signature:_____ Date: _____

Provider Signature:_____ Date:_____

Last updated 07/2018