BAY PEDIATRIC CLINIC Stimulant (ADHD Medication) Agreement and Consent Form

Date: _____

Patient Name: _____

Patient DOB: _____

To the Parent or Patient:

In Accordance with 902KAR55:110, it is our policy at Bay Pediatric Clinic, that patients (or their guardians) receiving prescriptions for controlled substances be required to sign a Controlled Substance Agreement. By Signing this agreement, I agree or I agree to follow for my child:

- I agree to take the medication **ONLY** as prescribed and I will not change the dose without getting approval from my physician or provider.
- I agree not to share, sell or otherwise dispense this medication wo anyone else.
- I agree not to seek ADHD medicine from any other source, including other physicians, emergency departments or clinics.
- I understand this medication has potential side effects including, but not limited to: appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping. These are less if these medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider.
- **I understand that after initiation of treatment, a follow up visit is required within 30 days, and then every 3 months after that. If there is a change in dosage needed then you will be asked to come back within 30 days. There are no exceptions to this rule. No refill of the medication prescribed for ADHD can be made if these follow up visits are not kept.**
- **I understand that refills of the medication are authorized once every thirty days as long as the required follow-up office visits are kept.** I will not be provided a refill prescription prior to this thirty-day period. Refill prescriptions cannot be mailed, or faxed. They can be sent electronically to the pharmacy. The prescription refill request must be called into our office every 30 days. Please allow 48 hours for medication refills.
- **I understand that to obtain a refill, I must call the clinic Monday-Friday 8:00am to 4:30pm three days before the refill expires to request a refill.** It is important to make sure that the patient has enough medication to get through weekends, holidays or after hours because the provider on call will not refill these prescriptions.
- I know that this medication is given to help control the effects of ADHD. It is not a cure. The duration of use is determined by the effectiveness of the treatment.
- I understand this medication is potentially addictive and chances of addiction are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider. This requires regular office visits to follow my progress.
- I agreed that this medication will be stopped if my ability to function does not improve, if the medication loses its effectiveness, if I do not attend required office appointments, or if there is reason to believe I am misusing the medication in any way.
- I have had the risks associated with taking this medication explained to me and have decided that the benefits outweigh the risks.

- If I am unable to take the medication due to allergic or otherwise adverse reaction. I will notify the prescriber and discard the remainder.
- I understand that if any of this medication needs to be discarded, I contact my local police department to locate a drug disposal location.
- I authorize Bay Pediatric Clinic to review medication information with other doctors, hospitals and pharmacists; additionally, to contact any groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers. All pharmacies and policing agencies.

Patient _____ Date: _____

Parent Signature (if patient is under 18 years) _____ Date: _____

Cop given to parent: _____ Date: _____
Staff Initials