Stimulant Consent Form

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long term use of stimulants such as methylphenidate (Ritalin®), dextroamphetamine/amphetamine (Adderall®), methylphenidate (Concerta®), lisdexamfetamine (Vyvanse®), and/or dexmethylphenidate (Focalin®) is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because stimulants have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of stimulants to treat your medical condition.

Please review the information listed here and put your initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

___ Prescribed stimulants must come from the provider whose signature appears below or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception. **(Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)**

___ Prescribed stimulants must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies **our office must be informed.** The prescriber assumes no liability related to actions of the pharmacy.

___ Notify provider of any new medications or medical conditions, and of any adverse effects you experience from any of the medications you take.

___ You may not share, sell, or otherwise permit others access to use your prescribed stimulants.

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

___ Stimulants should not be stopped abruptly.

___ **Unannounced pill counts, urine or serum toxicology screens will be requested, and your cooperation is required.** Presence of unauthorized substances (including but not limited to illegal drugs i.e. marijuana, cocaine, heroin, etc. other controlled medication) may prompt referral for assessment for addictive disorder.

___ I agree to not use any alcohol or illegal drugs when using stimulants.

___ No more than a small amount of stimulants should be carried on your person at any time and always should be in the original pharmacy container. The balance of meds should be stored in a private, secured location.

___ Since stimulants may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

___ Stimulants may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. **A police report should be filed for all regarding theft of medication.**

___ Early refills will generally not be given. **All appointments and scripts must be scheduled and obtained at least 14 business days prior to refill. All scripts are sent electronically.**

___ Prescribed stimulants may be issued early **ONLY** under extenuating circumstances. Written documentation of such circumstances must be provided and a follow-up appointment scheduled prior to authorization. Pharmacists may decline requests.

___ I understand when I take stimulants, that I may experience certain reactions or side effects that could be dangerous, including increased heart rate, elevated blood pressure, higher body temperatures, dilation of pupils, disturbed sleep patterns, hallucinations, hyperexcitability, irritability, bizarre/erratic/sometimes violent behavior, and/or addiction.

___ All confidentiality is waived and full release of records in verbal and or written format will be immediately provided to healthcare professionals or legal authorities related to implied or actual violation of this contract or tolerance/abuse/addiction concerns.

___ **I acknowledge that failure to adhere to these policies may result in cessation of controlled substance therapy prescribed by this physician, referral for further specialty assessment, and investigate by appropriate state and federal authorities.**

___ **It is understood that any medical treatment is initially a trial, and that continued therapy is contingent on evidence of benefit**.

___ **I understand that I will be subject to urine screens**, which will be given both on a random and quarterly basis. It is important to quantify the amount stimulants in the urine are necessary to verify the appropriate usage of the medication and possible diversion.

___ I affirm that you have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

___ Renewals are contingent on keeping scheduled appointments at least two weeks prior to refill date. No renewals without an appointment.

___ **For Women**: It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking stimulants and continue to take the medicines during the pregnancy, the baby and I will be subject to adverse maternal and neonatal outcomes, and will require treatment.

I have reviewed this form with my provider and have had the chance to ask any questions. I understand each of the statements written here and by signing give my consent for with benzodiazepines.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date