Chopra Pediatrics ADHD Medication Agreement and Consent Form

Date: _______________

Patient Name: _____________________________________

DOB: ________________

To the Parent/Guardian and Patient:

This agreement has been developed in the interest of promoting optimal drug therapy while minimizing risks to the patient, health care provider and society. It is our policy at Chopra Pediatrics that parents/guardians and adult patients receiving prescriptions for controlled substances be required to sign a Controlled Substance Agreement. By signing this agreement, I agree to the following:

1) I agree to give the medication to my child ONLY as prescribed and I will not change the dose without getting approval from my provider.

2) I agree not to share, sell or otherwise dispense this medication to anyone other than authorized caregiver for patient (i.e coparent, acting guardian, school nurse if indicated).

3) I agree not to seek ADHD medicine from any other source, including other providers, emergency departments, or clinics.

4) I understand this medication has potential side effects including but not limited to: appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, changes in blood pressure, and difficulty sleeping. These are less if the medications are prescribed to me in a controlled setting under close monitoring by my provider.

5) I understand that after initiation of treatment, a follow up visit is required within 30 days, and every 30 days until optimal dose of medication is reached. Subsequent visits will be every 2 months for maintenance therapy, unless a change in dose or medication is made, in which case a follow up visit will be required within 30 days until optimal dose is again reached. 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. **A parent or adult with written permission to bring child to appointment must be present at visit.**

6) 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 7**

days in advance of this thirty day period. Refill prescriptions cannot be mailed, faxed, written, or called in to the pharmacy. To become compliant with new rules and regulations regarding the dispensing of controlled substances, all new and refilled prescriptions will be electronically sent to the pharmacy on file.

7) I understand that **to obtain a refill, I must notify the office at least 48 business hours before I run out of medication for the patient**. I may do this via our patient portal or by phone. 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. Early refills will not be given for lost or stolen prescriptions/medication. There will be NO exceptions.

8) 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.

9) 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 provider. This requires regular office visits to follow my progress.

10) I understand that I should check with my provider or pharmacist before using other medications including over-the-counter and herbal products.

11) Provider may require random urine testing as a matter of routine monitoring

12) I understand that if I break this agreement, my provider reserves the right to stop prescribing stimulant medications for me.

Parent/Guardian Signature Relationship to patient Date

______________________ ___________________ _____________

Copy given to the parent: __ Yes __ No Date

Staff initials __________ _____________