Rockcastle Pediatrics & Adolescents Stimulant (ADHD Medication) Agreement and Consent Form

Date: _____

Patient Name: _____

Patient DOB: _____

Patient SS# or KY Drivers lic#: _____

To the Parent or Patient:
In accordance with 902KAR55:110, it is our policy at Rockcastle Pediatrics & Adolescents 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 that the patient will take the medication **ONLY** as prescribed and the dose will NOT be changed without getting approval from my physician or provider.
- I agree not to share, sell or otherwise dispense this medication to 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 the 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. 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, faxed or called in to the pharmacy. The prescription must be picked up at the office by the patient or another person for whom written consent is in the file.
- **I understand that to obtain a refill, I must call the clinic Monday-Friday 8:00 am to 4:30 pm the day before the refill expires, to request a refill to be picked up the next day the office is open**. 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 agree that only one pharmacy will be used to fill this ADHD medicine prescription**:

  The pharmacy I have selected: _____

  Pharmacy Address: _____

  Pharmacy Phone Number: _____

- 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 agree 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 anyway.

- 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 Rockcastle Pediatrics & Adolescents 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 Signature Date

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

FILL OUT THE FOLLOWING PORTION ONLY IF YOU WANT TO ALLOW ANOTHER ADULT TO PICK UP ADHD PRESCRIPTIONS FROM THE OFFICE

The names listed below are individuals (other than parent/guardian) permitted to pick up and obtain my child's ADHD prescription from RockPeds. The person listed below must be over the age of 18, and will be asked to provide photo identification when picking up a prescription. I understand that once I or a representative I have listed below has signed for my child's prescriptions, I will be held solely responsible for them. I understand that any lost or stolen prescriptions will not be replaced until the next due date.

_____
Name (Please print)

_____
Name (Please print)

_____ _____
Parent Signature Date

OFFICE USE ONLY:

Copy given to parent: _____ _____
Staff initials Date