ROCKCASTLE PEDIATRICS & ADOLESCENTS STIMULANT (ADHD MEDICATION) AGREEMENT AND CONSENT FORM

Date: _____

Patient Name: _____

Patient DOB: _____

Patient Soc Sec# or Driver's Lic#: _____

To the Patient or Parent:
In accordance with 902KAR55:11, 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:

1. 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.
2. I agree not to share, sell, or otherwise dispense this medication to anyone else.
3. I agree not to seek ADHD medicine from any other source, including other physicians, 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. These are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider.
5. **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. <u>No refill of the medication prescribed for ADHD can be made if these follow up visits are not kept.</u>**
6. **I understand that refills of the medication are authorized once every thirty days as long as the required office visits are kept**. I will not be provided a refill prescription prior to this thirty-day period.
7. **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**. 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 request these prescriptions.
8. **I understand that ADHD medication prescriptions are sent electronically by my child's provider to the pharmacy that I have selected.** I understand that there may be times that the electronic prescription system may fail, and in that case, a physical copy of the prescription will need to be picked up by the parent at the office. The prescription still must be filled at the pharmacy I selected.
9. **I agree that only one pharmacy will be used to fill this ADHD medicine prescription:**

    Pharmacy I selected: _____

    Pharmacy Address: _____

    Pharmacy Phone Number: _____

10. I know that this medication is given to help control the side effects of ADHD. It is not a cure. The duration of use is determined by the effectiveness of the treatment.
11. I understand this medicine 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.
12. 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; if there is reason to believe I am misusing the medication in any way.
13. I have had the risks associated with taking this medicine explained to me and have decided that the benefits outweigh the risks.
14. If I am unable to take the medication due to allergic or otherwise adverse reaction, I will notify the prescriber and discard the medication.
15. I understand that if any of this medication needs to be discarded, I contact my local police department to locate a drug disposal location.
16. I authorize Rockcastle Pediatrics & Adolescents to review medication information with other doctors, hospitals, and pharmacists; Rockcastle Pediatrics will be reviewing KASPER information before prescribing or refilling; additionally, to contact any groups and organizations involved with my care and involved with the investigation of medicine 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 old) Date

OFFICE USE ONLY:

Copy given to parent:

Staff Initials: _____ Date: _____