Coastal Medical
Lifespan. Delivering health with care.®

Coastal Medical
Stimulant Medication Agreement

Name: _____ DOB:____/____/____

Physician: _____

Medication: _____Strength: _____

Directions: _____

Medication: _____Strength: _____

Directions: _____

Condition Treated: _____

Desired Functional Outcome:_____

Date of Next Assessment:_____

Coastal Medical is committed to providing the safest care for our patients with attention deficit hyperactivity disorder (ADHD), which can impact the quality of patients' lives. While doing so, controlled substances may be used as a therapeutic option to relieve symptoms associated with this condition. Controlled substances include, but are not limited to stimulants (amphetamine, dexmethylphenidate, methylphenidate, etc.). This agreement is designed to help improve treatment outcomes, reduce risk for adverse events, and ensure proper use of controlled substances while adhering to both state and federal laws. The word "I", "me", or "my" refer to the patient. In cases where the patient is under 18 years of age, the parent or legal guardian is authorizing this agreement on behalf of the child.

1. I agree that the Coastal Medical Provider listed above and partners will be the only person(s) to prescribe stimulant medications for managing ADHD.
2. I understand the importance of taking this medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of my medication without first discussing it with my physician. I understand that expected prescription refill dates will be used to promote optimal use of this medication.
3. My physician may require random urine drug testing as a matter of routine monitoring.
4. I understand that I should check with my physician or pharmacist before taking other medications including over the counter and herbal medications.
5. I will obtain all **of** my prescriptions from one pharmacy chain to allow the pharmacist to check for drug- drug interactions. The exception would be an emergency situation where

the medication is unavailable at my usual pharmacy, in which case I will inform my physician. I agree to have my medication filled at the following pharmacy **chain**. The pharmacy that I have selected is:

Pharmacy Name:_____

6. I understand that refill requests for my controlled substances will be made only during scheduled office visit or during regular office hours. Refills requests made after hours will be addressed the next business day.
7. I understand that refills for my controlled substances will be sent to the above pharmacy chain via electronic prescribing in compliance with Rhode Island state regulations. In the event of electronic transmission failure, I understand that I may need to pick up a hard copy prescription from the office. I also understand that I may be asked to show my state identification when picking up prescriptions for me or my child/guardian.
8. I understand that if I lose my prescription it will not be replaced. I understand that if a replacement prescription is issued due to extenuating circumstances, it will be at the discretion of the physician.
9. I understand that medication changes will not be made between appointments after the initial titration period. I will call the office to schedule a next available appointment to allow the designated physician to determine if medication changes are needed.
10. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my medication to any other person. I acknowledge that my prescription will not be refilled before it is due.
11. I understand that if I break this agreement my physician reserves the right to stop prescribing for me.

Date:_____

_____ _____

(Signature of Patient/Parent/Guardian) *(Signature of Physician)*