RISKS AND CONDITIONS FOR CHRONIC STIMULANT TREATMENT AGREEMENT FOR PATIENTS ≥ 18 YEARS OLD

I agree to stimulant treatment for my Attention Deficit Hyperactivity Disorder (ADHD). The goal of this treatment is to help improve my ability to function in social and work activities by helping to manage my symptoms. I understand these medications may not eliminate my ADHD symptoms but may reduce them and improve what I am able to do each day.

This is a decision that I have made after fully discussing the risks, benefits, and alternatives of this treatment. I understand that if the above goal is not achieved, the medication may be tapered and discontinued. I understand that there is no guarantee that this medication will work.

Risks:

Stimulants are potentially dangerous, addictive and frequently mis-used.

I understand the treatment of ADHD with stimulants may be associated with risk, including but not limited to:

- Death due to accidental overdose.
- Physical Dependance, to stimulants when used to appropriately treat ADHD is very rare. Regular breaks ("Holidays") off the medication may be advised and are usually not associated with withdrawal symptoms of physical dependance. These symptoms include: runny nose, diarrhea, abdominal cramping, "goose flesh," and/or anxiety and severe emotional distress.
- Death when taken with alcohol or other illicit drugs/ or drugs associated with substance use disorder.
- Nausea, decreased appetite, unintentional weight loss.
- Insomnia, Headaches, and seizures.
- Elevated blood pressure, heart rate and an increased risk of cardiovascular events such as myocardial infractions (heart attacks), strokes, heart failure, arrythmias, heart damage (myopathy) and sudden death.
- Changes in mental or emotional state and thinking abilities including aggressive behavior, hostility, and psychosis.
- Known and unknown risks to a newborn if taken during pregnancy, including physical dependance of the baby.
- Some over-the counter (OTC) and prescription medications can interfere with the efficacy and safety of stimulant treatment so it is important to inform the office of any other prescription or OTC treatments (including herbal or nutritional supplements) you may be using.

BEACON PEDIATRICS

CHRONIC STIMULANT TREATMENT AGREEMENT

My primary care provider team will continue treating my ADHD with stimulants under the following conditions, which I agree to:

1. I agree to abstain from using any illegal drugs or other controlled substances not prescribed by my healthcare provider while under treatment with stimulants. I have informed my child's health care provider of any history of drug or alcohol use disorder or dependance.
2. I understand that my prescription may not be phoned or faxed into the pharmacy or mailed to my house by Beacon Pediatrics Staff.
3. When prescriptions are picked up in the office, I understand I must show a picture ID and sign for the prescription prior to release by the Beacon Pediatric Staff. If I am unable to come to the office to pick up the prescription, I will phone the office ahead of time and let the staff know who will be picking up the prescription and they will be required to present an ID at the time of prescription pickup.
4. I am not currently and will not become involved in the sale, illegal possession, diversion, or transport of controlled substances.
5. I will not allow other individuals to take my medication.
6. I understand that only a provider on my primary care team can change the dose or prescribe a different medication.
7. I will inform all my health care providers that I am taking a stimulant and any other prescription, over the counter (OTC) medications, and supplements (especially other controlled substances), and of the existence of this contract pertaining to stimulants. I will not obtain any stimulants from providers other than my primary provider named below or another provider on my primary care team.
8. I will consent to random urine tests to properly assess the effects of the stimulants I am prescribed to assess my compliance with my medical regimen, including screening for illicit drugs. Screening may also include pill counts to assure I am taking the medication as prescribed. Refusal to submit to drug screening or pill counts at the time specified may result in the cessation of further stimulant medication prescribing.
9. I recognize that good medical care is a team effort and I agree to participate in any medical, social, physical, psychological, or psychiatric assessment and therapy recommended by my primary care provider to help manage my ADHD.
10. I will keep all my scheduled appointments (at least once every 5-6 months more frequently per the discretion of my primary care team). During this appointment we will discuss your current condition, review your medications, address your concerns, and review your treatment goals. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled. If I miss an appointment, I understand that my stimulant medicine may not be refilled until I am seen again.
11. I will notify my primary care team if I am pregnant, am considering pregnancy, or if I become pregnant in the future.

Refills

1. I agree to call for and pick up my prescriptions at specific times and dates assigned to me by the office.
2. I will not ask for refills earlier than agreed. I will give at least 2 business days (Tuesday-Thursday, except holidays) notice for all refill requests. I understand that Beacon Medical does not process refill requests on weekends and holidays.
3. I understand if I run out of medication early, I will not receive an early refill, including:
    - If the drug is lost or damaged
    - If the drug is stolen-even if a police report is presented
    - If I increased my dose without the permission of my primary care provider team.

I understand that my primary care team may taper and/or stop prescribing stimulants and seek an alternative ADHD management plan, addiction treatment or behavioral health treatment if any of the following occurs:

- I do not show any improvement in my symptoms or functional activity.
- I give away, sell, or misuse the medications I am prescribed.
- I develop significant side effects from the medication that are detrimental to me.
- If test results indicate improper use of prescribed medication or use of illegal drugs or other substances not prescribed by my primary care provider team.
- I violate any terms of this agreement.

I HAVE READ AND UNDERSTAND THE RISKS AND CONDITIONS CONCERNING STIMULANT TREATMENT OF MY ADHD. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE. I ACKNOWLEGED THAT ALL OF MY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY.

I CONSENT TO THE USE OF STIMULANTS TO HELP CONTROL MY ADHD, AND I UNDERSTAND THAT MY TREATMENT WITH STIMUALTNS WILL BE CARRIED OUT IN ACCORDANCE WITH THE CONDITIONS STATED ABOVE.

SIGNED: _____ DATE:_____

PATIENT PRINTED NAME: _____

PROVIDER: _____ DATE:_____

PROVIDER PRINTED NAME: _____