Union University Health Service's Patient Agreement for Psychostimulant Medication

I have been prescribed a psychostimulant medication for the treatment of ADD, ADHD or other condition. I understand these medications are controlled substances and are tightly regulated by state and federal law because of a high risk for abuse. I understand my prescription will only be written for a one monthôs supply at a time, and that an appointment must be scheduled prior to receiving a refill.

I understand that it is a FELONY to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others for any reason.

I agree that my hometown or original prescribing clinician may be notified that my prescriptions are now going to be written by the Union University Health Services Physician and Nurse Practitioner.

I also agree that my hometown or original prescribing clinician may disclose to Union University Health Services when prescriptions have been written for me in his or her office. I will not seek to have duplicate prescriptions written for me for the same or similar medication.

I acknowledge that violation of the Union University Health Services policies concerning controlled substances will result in termination of my prescription for those substances and may result in judicial sanctions from the university, for violation of Unionôs community values.

If my medication is lost, stolen, or damaged, the prescription will not be rewritten before the renewal period. I acknowledge that I am responsible for protecting my medications from being lost or misused by other persons or animals. I acknowledge that it is both illegal and potentially

1. I, _____ agree that Union Health Services will be the only provider prescribing _____ (also known as STIMULANT), a medication for managing ADHD and that I will obtain all of my prescriptions for this medication at one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform Union Health Services as soon as possible.

_____2. I understand the importance of taking the medication at the dose and frequency prescribed. I agree not to increase the dose of the medication without first discussing it with my healthcare provider.

_____3. Union Health Services may require random urine testing as a matter of routine monitoring. ***(If you are asked to provide a urine specimen at your visit, the specimen must be collected prior to leaving the clinic or else it is an automatic fail.)***

_____4. I will attend all reasonable appointments, treatments and consultations as requested by Union Health Services. I will pursue other ADHD consultations/management strategies as necessary.

_____5. I understand that I should check with my prescriber or pharmacist before taking other medications including over-the-counter and herbal products.

_____6. I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my stimulant therapy. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my healthcare provider is not obligated to replace any medication shortfall.

_____7. I consent to open communication between Union Health Services and any other health care professionals involved in my ADHD management, such as pharmacists, other doctors, emergency departments, counselors, etc.

_____8. I understand that if I break this agreement, Union Health Services reserves the right to stop prescribing stimulant medications for me.

_____9. Since this medication requires lab monitoring, there is a management fee per semester as follows: Fall Semester $45 Spring Semester $45 Summer Semester (only if enrolled) $20.

Date: _____ _____

(Signature - Prescriber)

DOB: _____

_____

Student ID# _____ (Signature - Prescriber)

_____ _____

(Signature ï Patient) (Signature - Supervising Physician)

Date:_____

UNION UNIVERSITY