SEASIDE BEHAVIORAL HEALTH

Stimulant Agreement

Patient Name: _____ DOB:_____

My provider has agreed to prescribe a stimulant to manage the symptoms of my psychiatric illness and to help me function better in my life. The stimulant I am prescribed is _____; which treats my (condition)_____.

I understand the following about stimulant medications:

- I understand that the main goal of treatment with these medications is to improve my overall quality of life.
- I understand that these medications are in associated with risk for serious cardiovascular events including heart attacks, strokes, or sudden death – particularly in persons who have cardiovascular issues or family history of such - Patients with preexisting cardiac conditions should avoid the use of stimulant medications and the manufacturers of stimulant and related medications recommend a cardiac evaluation for any patient who present with cardiac symptoms.
- Other side effects include high blood pressure, increased heart rate, changes in vision, inability to sleep, headache, decreased appetite, stomach pain, dry mouth, weight loss, anxiety, and decreased sex drive. I will notify my provider if any of these occur.
- (FOR WOMEN) Stimulant medications can be harmful to developing babies. I understand the risk and will take appropriate precautions to avoid becoming pregnant or stop treatment before intentionally trying to conceive. If I should desire to seek treatment during pregnancy, I will discuss all treatment options and weigh safety risks/benefits for myself and my baby with my OBGYN and psychiatric provider.

I agree to the following regarding stimulant medications:

- I will take medications at the dose prescribed by my provider
- I will take medications at the frequency prescribed by my provider (we may discuss days off, lower dosing as appropriate)
- I will not change how I take these medications without the prior approval of my provider
- I will not request early refills
- Lost or stolen medications will not be replaced; I am responsible for my medications
- I will arrange for refills at the prescribed interval only during clinical hours
- All prescriptions will be written, on a 30 day schedule unless otherwise noted (90 day maximum allowance between visits)
- I will not request these types of medications from providers outside of Seaside Behavioral Health
- I will keep my medication list updated and current with Seaside Behavioral Health
- I will keep appointments with my psychiatric provider at Seaside Behavioral Health
- I will actively participate in the treatment plan as agreed upon with my provider at Seaside Behavioral Health
- I agree that I will not use marijuana, or illicit substances while taking this medication
- I agree that I may be subject to random drug screens and pill counts
- I understand that if my drug screen indicates that I am not taking these medications correctly- my provider can discontinue these medications
- I understand that if my pill count suggests that I am taking the medication differently than prescribed -my provider will discontinue these medications
- I will not sell, trade or give my prescription medication to anyone. I will keep these medications away from children
- I understand that failure to comply with the above may cause my provider to discontinue prescribing these medications
- I understand that if I do not show improvement in symptoms that my provider may stop prescribing these medications
- I understand that my provider may stop these medications if I show significant side effects or intolerance

My provider has reviewed the above with me. I have read this agreement and agree to all terms as outlined above. All questions have been answered and I agree to use the stimulant as a part of my overall treatment plan.

Patient Name: _____ Patient Signature _____ Date _____

Provider Name: _____ Provider Signature _____ Date _____