INTERMED
Care without compromise.

InterMed Stimulant Agreement

We have discussed treating you/your child on a stimulant medication. This document outlines the expectations for patients, families, and providers when stimulants are prescribed. Most importantly, to ensure you are getting the best care possible, we will need your active participation and honest feedback on the effects of the medication(s). If you have questions or concerns about your treatment, please share them.

I/my child: _____ DOB: ___/___/_____, have agreed to use this medication as part of my/my child's treatment for a diagnosis of:

_____.

I agree to the following:

- I am responsible for my/my child's medications. I will not share, sell, or trade my/my child's medication. I/my child will not take anyone else's medications.
- I will not increase or change how my/my child's medication is taken until I speak with my provider.
- My/my child's medication may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I agree to give consent to a urine drug screen for myself/my child if my provider deems it necessary. If appropriate, we may need to account for the number of pills taken during treatment. If a pill count is requested, I will bring my/my child's medication, in the original container, to InterMed at the requested time so that the clinical staff may verify the number of pills.
- I agree that monitoring and refill of the medication will be conducted by my/my child's provider in office visits at regular intervals.
- I will notify my/my child's provider if I/my child is prescribed a controlled substance medication by another provider.
- I will notify my/my child's provider if I/my child become(s) pregnant since stimulants pose risks to the fetus during pregnancy.

_____(patient/parent/guardian initials)

Refills:

Refill requests will be made by phone Monday through Friday. Refill requests won't be processed on nights, weekends, or holidays. It may take up to 3 business days to process refill requests.

Substance Use:

The use of substances of abuse while taking stimulants can be unsafe and may interfere with the benefit of the medication. Please notify your/your child's provider of any known or suspected substance abuse.

Provider Responsibility:

- We will make sure that this treatment is as safe as possible. We will check regularly to make sure that you/your child is not having adverse effects.
- We will discuss with you additional forms of treatment to help with you/your child's condition.
- We will keep track of your prescriptions using the Maine Prescription Monitoring Program (PMP) regularly as required by law.
- We will conduct urine drug testing as indicated.
- We may need to contact other providers or family members to get information about you/your child's care and/or use of this medication. We will ask you to sign an authorization for release of information if permission for communication is not already documented. We will work with any other providers that you are seeing so that they can treat you safely and effectively.

Termination of Agreement:

If I do not fulfill the responsibilities above or if my/my child's provider determines that the harms of this medication outweigh the benefits, this medication may be stopped by my provider in a safe way.

Patient Signature: _____ Date: ___/___/_____

Parent/Guardian Signature (for patients under the age of 18): _____

Provider Signature: _____