PSYCHOSTIMULANT MEDICATION INFORMED CONSENT AND AGREEMENT **University Health Services** **University of Massachusetts** **Amherst, MA 01003** **413-577-5000**	**L A B E L**	IDX MRN: _____ Last: _____ First :_____ M:_____ DOB: _____ Sex: ___ Time: __ DOS: _____ Clinic: _____ Visit #: _____ Provider: _____

I have been prescribed psychostimulant medication for treatment of Attention Deficit/Hyperactivity Disorder (ADHD) or other medical condition. When appropriately prescribed for a particular person and documented condition, they are generally safe when used as directed.

I understand these medications are **controlled substances**, strictly regulated by state and federal law, because of their potential for misuse, abuse and diversion. I acknowledge that it is both illegal and potentially very dangerous to share prescription medications or sell them to another person. Mixing stimulant medications with other prescription medications, over-the-counter medications, alcohol or other drugs can be dangerous.

I understand that it is a felony to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to either give or sell these medications to anyone else.

I agree that my University Health Services (UHS) or Mental Health Services (MHS) prescriber may notify my medical provider at home that prescriptions will be written by UHS or MHS prescribers, and that my provider at home may disclose when prescriptions have been written in his or her office. I will not seek duplicate prescriptions of the same medication.

Prescriptions will be written by only one regular prescriber, except for a pre-arranged and designated alternate prescriber during my regular prescriber's extended absence.

If a prescription is lost, stolen or damaged, or the medication is misplaced, the prescription will not be rewritten prior to the renewal period. A copy of a police report may be required before a lost or stolen prescription is refilled. It is my responsibility to protect and secure both the prescription and the medication safely so that they are not misplaced, lost or misused by others.

Medication refills are for a one-month supply. My prescriber may require monthly appointments if I am a new patient, or if a medication or dosage has changed. Once my prescriber feels that a medication and dosage have been stabilized, my appointments may be spread to once or twice a semester. If I recurrently miss my appointments, I may not be given a refill. I will allow at least a 48 – 72 hour period for refills. Refills are never given at night or on weekends.

I understand that by signing this agreement, I must abide by it, and that failure to do so will result in the termination of my psychostimulant medication prescriptions.

_____ _____ _____ _____

Patient signature Date Prescriber signature Date