RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

PEDIATRIC CONTROLLED SUBSTANCE AGREEMENT

_____ _____/_____/_____
PATIENT NAME *DATE OF BIRTH*

_____ _____/_____/_____
PROVIDER *TODAY"S DATE*

Controlled substance medications are one part of the treatment for: _____
PRINT NAME OF CONDITION (e.g. ADHD, Anxiety)

The goals of this medicine are: To help control the effects of my child's condition(s), stated above, as much as possible without causing dangerous side effects. I understand it is not a cure for ADHD.

The patient's parent or legal guardian must *initial* each statement after reviewing

_____ The patient's provider has completed medication counseling which includes the following information:

1. The patient should not drink alcohol or use drugs/substances while taking controlled substances. If I become aware that my child is using these substances, I will notify their provider immediately.
2. Treatment with controlled substances may be discontinued or dose adjusted if medically necessary, stimulants will not cause withdrawal if they are stopped.
3. I understand that controlled substances can be misused or abused, or lead to addiction.

As the patient's parent or legal guardian I understand, am responsible for and voluntarily agree that:

_____ The patient will keep, and be on time for, all their scheduled appointments with the provider.

_____ The patient will participate in all other types of treatment that they are asked to participate in.

_____ The medication will be kept safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until the patient's next appointment, and may not be replaced at all.

_____ I will ensure that the medication is taken only as instructed and not change the way it is taken without first talking to the provider.

_____ The controlled substance prescription will be filled only by the client's psychiatrist provider. Any prescriptions given by other providers in emergency situations must be disclosed with the clinic within 2 business days.

_____ I will make sure the patient has an appointment for refills. I will call at least 5 business days ahead if I need a refill of my prescription. I know that refills will only be granted during my provider's regular business hours.

_____ It is illegal to, and therefore will not, sell this medicine or share it with others. I understand that if I or my child does, the treatment will be stopped.

_____ I will sign a release of records form to let the provider speak to all other providers that the patient may see and release any psychological testing results. I will inform the provider of all other medicines that the patient takes, and let him/her know right away if the patient receives a prescription for a new medication.

_____ I will use only one pharmacy to fill the prescription.

_____ _____
PHARMACY NAME & ADDRESS *PHONE NUMBER*

_____ I understand my child may be subject to random drug testing in the office.

_____ If the provider recommends to treat the cause of the patient's conditions, as stated above, said Provider will change the prescription to wean off or decrease the medication dose.

_____ The patient may lose their right to treatment in this office if I or the patient breaks any part of this agreement.

_____
PARENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)

_____ _____/_____/_____
PARENT OR LEGAL GUARDIAN SIGNATURE *TODAY'S DATE*

_____
PROVIDER NAME (PLEASE PRINT)

_____ _____/_____/_____
PROVIDER SIGNATURE *TODAY'S DATE*