St. Clair County Community Mental Health Authority

Stimulant Requirement Agreement

Stimulant drugs consist of any form of methylphenidate (e.g. Ritalin) or amphetamines (e.g. Adderall). These drugs have abuse potential. The following requirements are needed to be agreed upon by the person receiving the prescription for any of these medications.

Participant's Name: _____ Case #: _____ Date: _____

An individual who wishes to receive a prescription for any stimulants freely and voluntarily agrees to accept the following agreements:

1. I agree to keep and be on time to all my scheduled appointments.

2. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my prescription is a serious violation of this agreement and will result in my medication prescription being terminated. I am aware that I will at random be required to submit to a pill count and urine drug screen periodically.

3. I agree that this medication will be prescribed at my scheduled visits with my CMH prescriber. Missing my appointments can subject me to a drug withdrawal reaction.

4. I agree that the medication I receive is my responsibility and I agree to keep it in a safe secure place. I agree that lost medication will not be replaced regardless of why it was lost.

5. I will not leave my medication in a public part of my home, leave the bottle open or near water or children. I am aware that these medications can be very dangerous to children.

6. I agree not to obtain controlled substance prescriptions from any doctors, pharmacies or other sources without informing CCMH prescriber.

7. I understand that mixing stimulants with alcohol, narcotics such as heroin, narcotic analgesics such as Fentanyl, Norco, Percocet, methadone, Suboxone, Tylenol with Codeine, Kratom, cocaine or other street drugs can be life threatening. I will avoid alcohol. I will avoid all such medications, prescribed by other prescribers or off the street and this includes cannabis and all products containing THC.

8. I understand that mixing stimulants with alcohol, narcotics, cocaine or other street drugs can be life threatening. I will avoid all other addicting drugs, either prescribed by doctors or off the street and this includes marijuana.

_____ _____

Signature Date

_____ _____

RN Signature Date

_____ _____

Prescriber Signature Date

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9. I agree to carry my medications in its prescription bottle or carry a copy of the prescription label with me.

10. I agree to take my medication as instructed and not alter the way I take my medication without first consulting my prescriber.

11. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in a treatment program as discussed and agreed upon with my prescriber and case holder.

12. I agree to provide random urine samples when requested by any CMH clinical staff to check for prescribed medication and any substances of abuse or alcohol in my system.

13. CMH prescribers and I have discussed this agreement and I agree that violation of any part of this agreement may be grounds for discontinuation of all controlled substances prescriptions.

14. I agree to sign Consent to Exchange Health Information for my prescriber to communicate with any professional prescribing medications for me and exchange my protected health information regarding my mental health and substance abuse history.

15. I have received a copy of this agreement.

_____ _____

Signature Date

_____ _____

RN Signature Date

_____ _____

Prescriber Signature Date