**Patient-Caregiver Agreement for Psychostimulant Therapy**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (caregiver) agree that Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be the only physician prescribing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (also known as STIMULANT), for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient). This medication is for managing ADHD. I will obtain all of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient) prescriptions for this medication at one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform the physician as soon as possible.
2. I (caregiver) understand the importance of giving the medication at the dose and frequency prescribed by the physician. I agree not to increase the dose of the medication without first discussing it with the physician. I understand that expected prescription refill dates will be used to promote optimal use of this medication.
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient) physician may require random urine testing as a matter of routine monitoring.
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient) will attend all reasonable appointments, treatments and consultations as requested by my physician. I (caregiver) will pursue other ADHD consultations/management strategies as necessary.
5. I (caregiver) understand that I should check with my physician or pharmacist before giving other medications including over-the-counter and herbal products.
6. I (caregiver) agree to be responsible for the secure storage of \_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) medication at all times. I understand the importance of not informing others about \_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) stimulant therapy. I agree not to give or sell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) prescribed medication to any other person. I acknowledge that the physician is not obligated to replace any medication shortfall.
7. I (caregiver) consent to open communication between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) doctor and any other health care professionals involved in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) ADHD management, such as pharmacists, other doctors, emergency departments, etc.
8. I (caregiver) understand that if I break this agreement, the physician reserves the right to stop prescribing stimulant medications for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient).

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Signature-Patient) (Signature – Physician)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature – Caregiver)

Adapted from [www.RxFiles.ca](http://www.RxFiles.ca) customizable form