Youth For Tomorrow
Joe Gibbs Founder
OUTPATIENT SERVICES

CONSENT TO MEDICATION MANAGEMENT

Name of Patient: _____ Pharmacy Phone: (_____)_____

Preferred Pharmacy (Name): _____ Pharmacy Location:_____

I_____ **(patient's name)** voluntarily request Youth For Tomorrow Behavioral Health Services (YFT-BHS) to treat my condition which has been explained to me as _____ **(condition).** I hereby authorize and give my consent to administer or prescribe the prescription(s) for dangerous and/or controlled substance(s) (medication(s)) as part of therapy or treatment for my condition. It has been explained to me that these medication(s) may include opioid/narcotic, anti-anxiety, insomnia, ADHD, etc. drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. Alternative methods of treatment, possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I have been informed and understand that I may be instructed to undergo medical tests and examinations before and during my treatment. Those tests will be ordered lab work and evaluations if and when it is deemed necessary, and I hereby agree to undergo the prescribed tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in my being discharged from my YFT-BHS Medical Doctor (MD) or Psychiatric Nurse Practitioners (PNP) care.

For ALL patients:

The most common side effects that could occur in the use of the drug(s) used in my treatment include but are not limited to:

1. Constipation
2. Nausea or vomiting
3. Excessive drowsiness or sleepiness
4. Itching
5. Urinary retention (inability to urinate)
6. Orthostatic hypotension (low blood pressure)
7. Irregular heartbeat
8. Insomnia (inability to sleep)
9. Depression
10. Impaired judgment and or reasoning
11. Respiratory depression (slow or no breathing)
12. Impotence
13. Tolerance to medication(s)
14. Physical and emotional dependence, addiction and/or insomnia (inability to sleep)

I understand and agree to the following:

1. This **Medication Management Agreement** relates to my use of any and all medication(s).
2. Medication(s) for the management of my condition will be provided by my MD or PNP so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my YFT-BHS physician's care and treatment.
3. Discharge from YFT-BHS medication management may be immediate for any inappropriate behavior and/or non-compliance.
4. I will use the medication(s) exactly as directed by YFT-BHS.
5. Use of illegal substances, alcohol, and other mood altering drugs can lead to dangerous side effects. Any evidence of use of illegal substances may lead to discontinuation of the medication(s)
6. Youth For Tomorrow Behavioral Health Services may at any time choose to discontinue the medication(s) for the treatment of my condition.
7. I will disclose to YFT-BHS all other medication(s) that I take at any time, prescribed by any Medical Doctor and or Dentist other than my YFT MD or PNP.
8. I agree that I shall inform any Medical Doctor and or Dentist who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.
9. I will stop all other medication(s) for the management of my condition unless otherwise directed by YFT-BHS.
10. I agree to inform my MD or PNP of any scheduled surgeries and / or Dental procedures in a timely manner to allow any alterations of the medication(s) dosage.

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11. I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).
12. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.
13. I agree not to obtain or seek to obtain any other medication(s) from any other source (including Emergency Department, "urgent care clinic," etc.) without first contacting YFT-BHS. Information that I have been receiving other medication(s) prescribed by other Medical Doctor and or Dentist that has not been approved by Youth For Tomorrow may lead to a discontinuation of the medication(s) and treatment.
14. I understand that the State of Virginia tracks information provided by pharmacies regarding all controlled substance prescriptions. Youth For Tomorrow may access this data through https://virginia.pmpaware.net at any time if there is concern that I may be violating this agreement.
15. I will notify YFT-BHS during office hours (9-5:30 Mon-Fri) at least five (5) business days in advance before running out of medication(s) so the medication management appointment can be made.
16. I understand that refills will NOT be ordered before the scheduled refill date even if my medication(s) runs out.
17. I understand that I will not be prescribed benzodiazepines if another non-addictive medication can be used. I will work with YFT-BHS to try alternative medication(s) or taper myself off of previously prescribed medication(s). I will not hold YFT-BHS liable for problems caused by the discontinuance of the medication(s).
18. I must keep all follow-up appointments as recommended by YFT-BHS and / or medication(s) may be discontinued.

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of non-treatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.
3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent agreement.

Prescription Monitoring Program Check Agreement:

In response to serious public health concerns related to prescription drug abuse in Virginia, the General Assembly has passed legislation establishing a statewide Prescription Monitoring Program. This program collects prescription data for specified drug schedules into a central database, which can then be used by authorized users to promote the appropriate prescribing and dispensing of controlled substances for legitimate medical purposes while deterring the illegitimate use of these drugs.

As authorized users of the program, prescribers in this practice/facility may request information from the Program on all Schedule II-IV prescriptions previously dispensed to a patient in order to establish a treatment history of the patient as assist them in making future treatment decisions. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. Only those persons authorized by law can be provided information from the database.

I_____ **(patient name or if it's a minor Parent/Legal Guardian name)** agree to and understand all the above statements and conditions.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
YFT-BHS Staff Signature Date