Pharmacological Management Procedure

At Syntero, our goal is to provide excellent psychiatric care. Thank you for trusting us with your care. To ensure you have a positive experience, it is important for us to explain how our psychiatric (medication) services are provided and what we expect of you as the client. Please read the pharmacological management procedure and ask any questions you may have.

1. Your initial appointment with psychiatry will be for an assessment. This appointment is 60 minutes. Your provider will ask many questions to get to know you and to give you the best care possible.
2. Follow-up appointments will be scheduled for 20 minutes and providers will decide when the next appointment should be scheduled based on best practice guidelines.
3. Many psychiatric symptoms are best treated with a combination of medication and therapy/support services. At Syntero, we expect you to continue in therapy and/or case management while you are receiving medication management services. If you are going to stop counseling or case management, you will be asked to find medication management services elsewhere in the community (another psychiatry provider or your primary care provider).
4. Medication refills and concerns should be addressed during psychiatry appointments whenever possible. If a refill is needed prior to the next scheduled psychiatry appointment, **we require a 5-day notice to refill medications**. Most of our providers work part time and this allows them time to be notified by their next scheduled work day. In the event you need to contact us regarding medication issues or refills between appointments, please call our NURSE LINE at extension 426. Please note that Friday calls may not be addressed until Monday. Remember that the nurse line is not for crisis calls.
5. Calls to schedule an appointment or to discuss a bill or any other non-medical calls should be directed to the main office number at your site.
6. Sometimes your insurance will require a prior authorization for medications. It can take up to 2 weeks for us to process this with your insurance. We will work with you to get your medication by completing prior authorizations, giving some limited samples, or helping with patient assistance programs through the pharmaceutical companies.
7. If, at any time, you believe you are experiencing medication issues that cannot wait until our psychiatry department can respond to you, you may contact your primary care provider or proceed to the nearest emergency room. Please be aware that **Syntero is not a crisis center**. If you are in crisis, please call the National Mental Health and Suicide Helpline 988, HelpLine (Delaware County) at 1-800-684-2324, the Suicide Hotline at 1-800-273-8255, or go to the nearest ER.
8. Please be sure to call ahead if you cannot keep your scheduled appointment. If you do not give 24 hours' notice, you may be charged a no-show fee of $25. If you miss three or more appointments without sufficient notice (all providers), your services with Syntero, Inc. may be terminated.

   By signing below, I understand and agree to the terms listed in this procedure. I consent to a psychiatric assessment and follow up medication management appointments.

   My signature also confirms that all of my questions or concerns regarding this procedure have been addressed by my psychiatry provider, therapist or CPST worker.

Client/Parent/Guardian Name	**Signature**	**Date**

Syntero's Psychiatry Support Line: 614.889.5722 Option 1 or www.Syntero.org/nurse-line
Poison Control (in case of overdose or accidental ingestion): 1-800-222-1222

CONTROLLED SUBSTANCE STIMULANT CONTRACT AGREEMENT

I understand that stimulant medication may be prescribed for me. By signing this contract, I agree to comply with the statements below for the safe and effective use of the prescribed medication. I agree to the following:

1. The medication is prescribed for my use only. I will not give, lend, sell, or share my medication with anyone. Any violation of the use of the stimulant medication is a criminal offense (felony) and will result in the discontinuation of my prescription.
2. The medication will be stored in a safe and secure place, preferably locked and out of sight.
3. I will take the medication as prescribed. I will not increase or decrease the dosage or make any changes in dosing without the approval of my prescriber.
4. I will keep regular appointments with my prescriber. Missed appointments may result in the cancellation of my stimulant prescription.
5. Lost or stolen medication will not be replaced. I will not request early refills.
6. I understand that using alcohol or taking illegal drugs while using a stimulant medication is dangerous.
7. I will abstain from the use of marijuana or other illicit drugs while taking stimulant medication. I understand that their use will jeopardize my continued prescription of stimulants.
8. I agree to random urine drug testing within 24 hours of being contacted by my prescriber's office. Failure to complete the testing will jeopardize my continued stimulant prescriptions.
9. I agree to bring in my medication at any time, within reason, for a pill count to ensure that I am taking my medication as prescribed.
10. I understand that Syntero will not tolerate the misuse of stimulant medication prescribed. I acknowledge that failure to follow these guidelines will lead to a break in this contract and may result in the discontinuation of my stimulant medication prescription.

I understand and agree to abide by this policy.

Patient Name (Print)	Patient Signature	
Prescriber Name (Print)	Prescriber Signature	Date

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Client Name: _____ DOB: _____ Date: _____

ADHD CARDIAC SCREENING QUESTIONNAIRE

Please complete the following. If you answered "YES" to any question, please explain at the bottom of this page.

QUESTIONNAIRE	YES	NO
1. Have you or anyone in your family ever lost consciousness or fainted?	☐	☐
2. Have you or anyone in your family ever lost consciousness or fainted DURING or AFTER EXERCISE?	☐	☐
3. Have you ever had chest pain, chest discomfort, or shortness of breath DURING EXERCISE?	☐	☐
4. Have you ever had an unexplained, noticeable change in exercise tolerance, where you became tired for no reason?	☐	☐
5. Have you ever had palpitations of the heart, heart racing without reason, or extra or skipped heart beats?	☐	☐
6. Have you ever had a heart murmur OTHER THAN an innocent/benign heart murmur, or history of any other heart problem?	☐	☐
7. Have you ever had high blood pressure, high cholesterol, or a heart infection?	☐	☐
8. Has a doctor ever ordered a test for your heart such as an ECG or echocardiogram?	☐	☐
9. Have you or anyone in your family ever had a seizure?	☐	☐
10. Have you ever had rheumatic fever, or disease of the heart valves?	☐	☐
11. Has anyone in your family died suddenly for no apparent reason, for example, by drowning, or a car accident, or by just dropping over?	☐	☐
12. Has anyone in your family under age 50 died suddenly from a cardiac cause or had a heart attack?	☐	☐
13. Has anyone in your family under age 40 ever required resuscitation-- for example, fainting and needing someone to revive him or her?	☐	☐
14. Has anyone in your family died suddenly during exercise?	☐	☐
15. Has anyone in your family had abnormal rhythms of the heart, cardiomyopathy, or problems with the heart muscle, Wolff-Parkinson-White syndrome, long QT syndrome, or any other heart syndrome?	☐	☐
16. Is there anyone in the family with Marfan syndrome?	☐	☐

Please explain all "YES" answers here, or note any other concerns you have about your heart health or that of family members:

Questions are based upon American Heart Association and American Academy of Pediatrics recommendations for cardiac screening, as well as from Vetter et al, Cardiovascular monitoring of children and adolescents with heart disease receiving stimulant drugs. *Circulation.* 2008 May 6;117(18):2407-23.

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PSYCHIATRIC HEALTH HISTORY QUESTIONNAIRE

This form is to be completed by client/parent/guardian/foster parent and reviewed by medical staff.

Has the client had any of the following health problems? (If never, leave blank)	**Now**	**Past**	**If you received treatment, add the type and date(s):**
1. AIDS/HIV	☐	☐	
2. Anemia	☐	☐	
3. Anxiety	☐	☐	
4. Arthritis	☐	☐	
5. Asthma	☐	☐	
6. Bipolar Disorder	☐	☐	
7. Bleeding Disorder	☐	☐	
8. Blood Pressure (high or low)	☐	☐	
9. Bone/Joint Problems	☐	☐	
10. Cancer	☐	☐	
11. Cirrhosis/Liver Disease	☐	☐	
12. Depression	☐	☐	
13. Diabetes	☐	☐	
14. Eating Disorder	☐	☐	
15. Epilepsy/Seizures	☐	☐	
16. Eye Disease/Blindness	☐	☐	
17. Fibromyalgia/Muscle Pain	☐	☐	
18. Glaucoma	☐	☐	
19. Head Injury/Brain Tumor	☐	☐	
20. Headaches	☐	☐	
21. Hearing Problems/Deafness	☐	☐	
22. Heart Disease	☐	☐	
23. Hepatitis/Jaundice	☐	☐	
24. Hyperactivity/ADD	☐	☐	
25. Kidney Disease	☐	☐	
26. Learning Problems	☐	☐	
27. Lung Disease	☐	☐	
28. Menstrual Pain	☐	☐	
29. Oral Health/Dental	☐	☐	
30. Schizophrenia	☐	☐	
31. Sexual Problems	☐	☐	
32. Sexual Transmitted Disease	☐	☐	
33. Sleep Disorder	☐	☐	
34. Speech Problems	☐	☐	
35. Stomach/Bowel Problems	☐	☐	
36. Stroke	☐	☐	
37. Suicide Attempts/Thoughts	☐	☐	
38. Thyroid	☐	☐	
39. Tuberculosis	☐	☐	
40. Other	☐	☐	

Please note family history of any of the above conditions and client's relationship to that family member.

Do you have a healthcare advanced directive? ☐ Yes ☐ No
If **Yes**, please provide a copy

NUTRITIONAL SCREENING: Please check box if there have been any recent changes

Height: _____ft _____in	Height changed within past year?	☐ Yes	☐ No	Yes, how much?
Weight: _____lbs.	Weight changed within past year?	☐ Yes	☐ No	Yes, how much?

Has your thirst:	☐ Decreased	☐ Increased	☐ No change
Has your appetite:	☐ Decreased	☐ Increased	☐ No change
Do any apply?	☐ Nausea	☐ Special diet? Please Specify: _____	☐ Vomiting
	☐ Picky Eater	☐ Trouble chewing or swallowing	

PAIN SCREENING

Does pain currently interfere with your activities? ☐ Yes ☐ No
If yes, what is the source of the pain and the treatment regimen?
If yes, how much does it interfere with your activities? ☐ Extremely ☐ Mildly ☐ Moderately ☐ Severely ☐ Not at all

PREGNANCY AND MENSTRUAL HISTORY (☐ does not apply)

Currently pregnant? ☐ Yes ☐ No	If yes, expected delivery date:
Currently breastfeeding? ☐ Yes ☐ No	Any significant pregnancy history?
Age at first menstrual period?	
Last menstrual period:	

ALLERGIES OR DRUG SENSITIVITIES: If you have any of the following please check and specify as best you can:
(☐ None)

☐ Food:
☐ Medication:
☐ Other:

IMMUNIZATIONS: Only required for children or individuals with developmental delays.

☐ 1.Chicken Pox	☐ 5. Measles	☐ 8. Small Pox
☐ 2.Diphtheria	☐ 6. Mumps	☐ 9. Tetanus
☐ 3.German Measles	☐ 7. Polio	☐ 10. Other
☐ 4.Hepatitis B		

LAST PHYSICAL EXAMINATION: (Client does not have a Primary Care Physician ☐)

Primary Care Doctor	Phone number
Address/Location	Date of last visit

Has the client had any of the following symptoms in the past 60 days?

☐ 1. Ankle Swelling	☐ 14. Hair Change	☐ 27. Shakiness
☐ 2. Bed-wetting	☐ 15. Hearing Loss	☐ 28. Sleep Problems
☐ 3. Blood in stool	☐ 16. Lightheadedness	☐ 29. Night Sweats
☐ 4. Breathing Difficulty	☐ 17. Memory Problems	☐ 30. Swelling
☐ 5. Chest Pain	☐ 18. Mole/Wart Changes	☐ 31. Tingling in limbs
☐ 6. Confusion	☐ 19. Muscle Weakness	☐ 32. Tremor
☐ 7. Loss of Consciousness	☐ 20. Nervousness	☐ 33. Urination Difficulty
☐ 8. Constipation	☐ 21. Nosebleeds	☐ 34. Vaginal Discharge
☐ 9. Coughing	☐ 22. Numbness	☐ 35. Vision Changes
☐ 10. Cramps	☐ 23. Panic Attacks	☐ 36. Vomiting
☐ 11. Diarrhea	☐ 24. Penile Discharge	☐ 37. Other:
☐ 12. Falling	☐ 25. Pulse Irregularity	☐ 38. Other
☐ 13. Gait Unsteadiness	☐ 26. Seizures	

HOSPITALIZATIONS: Has the client had medical hospitalizations/surgical procedures in the last 3 years? Additional space provided in the ADDITIONAL INFORMATION page

Hospital	City	Date	Reason

SUBSTANCE USE HISTORY/CURRENT USE: Please check all that apply

Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use
1. Alcohol, Beer, Wine				7. Inhalants			
2. Anxiety Medication				8. Marijuana			
3. Cocaine, Crack				9. Pain Medication			
4. Hallucinogens				10. Sleep Medications			
5. Hashish				11. Stimulants			
6. Heroin				12. Other			

Caffeine use: ☐ Yes ☐ No	**If yes, from where** (I.e. coffee, tea, pop, etc.):	**How much a week?** (I.e. cups, cans, bottles, etc.):
Tobacco use: ☐ Yes ☐ No	**If yes, from:** (I.e. packs, cartridges, etc.)	**How much a week?** (I.e. cigarettes, smokeless, etc.)

LIST OF CURRENT MEDICATIONS: List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, Albuterol, Nitroglycerin, etc.).

Medication	Dose	Frequency	Reason	Start date	Prescriber

ADDITIONAL INFORMATION

Feel free to use this space to add any additional information you wish your prescriber to know.

If the document was completed by a Parent/Guardian/Custodian:	
Name	Address
Signature	Phone number

FOR STAFF USE ONLY		
Name of Nurse Reviewing Information	Signature of Nurse Reviewing Information	Date
Print Name of NP/CNS/MD Reviewing Information	Signature of NP/CNS/MD Reviewing Information	Date

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PSYCHIATRIC SUPPORT LINE
614.889.5722 - option 1

A dedicated voicemail line designed to support medication questions, refills, and prior authorization needs.

However, if this is a crisis, please hang up and dial 988, the National Mental Health and Suicide Helpline, to be linked to a Mental Health Specialist, or go to your nearest emergency department.

When leaving a voicemail, clearly state:

- Client's first & last name
- Client's date of birth
- Name of medication & dosage
- Reason for the voicemail
- Callback number
- Pharmacy name & call number

Any Form Requests are completed during appointments **only**.

For additional information please visit:
WWW.SYNTERO.ORG/PSYCHIATRIC-SUPPORT-LINE

SERVICES

- MEDICATION QUESTIONS
  All questions about your medication, including side effects. Visit our website for more information.

- MEDICATION REFILL
  If a refill is needed prior your next scheduled appointment, call your pharmacy first to ensure a refill isn't already available. Requests made through the Psychiatric Help Line can take up to one week. Syntero does not initiate a refill request by pharmacies. Refills for controlled substances will only be addressed during scheduled visits

- PRIOR AUTHORIZATIONS
  Prior authorization for medication can take up to several weeks.

Meet the Pharmacy Team

Genoa Pharmacy is located inside the Dublin Syntero Counseling Center. We work alongside your Syntero healthcare team to seamlessly provide your medications after you're seen by a provider. Please reach out to us at the contact information provided below with questions.

Aimee, Mary Ellen, Alejandra, and Ryan

7 reasons to use Genoa Healthcare pharmacy:

1. We fill and synchronize all medications (behavioral and primary care)
2. We can mail prescriptions at no additional cost, reducing the need to visit a pharmacy.
3. We offer curbside pickup and provide same day delivery for urgent items, next day via FedEx, and standard mail (2-3 days) all for FREE.
4. We process and administer immunizations and LAIs
5. We proactively research copay assistance programs to reduce consumers' out-of-pocket costs
6. We have three packaging options
    I. Bottles
    II. Bubbles (Monthly cards)
    III. Dispills (Weekly packages with morning, noon, evening, and bedtime dosing slots)
7. A peer reviewed study found consumers using a Genoa pharmacy had adherence rates of more than 90%, 40% fewer hospitalizations and 18% fewer ER visits.

Have questions or want to learn more? Call the pharmacy today!

Phone: (614) 763-2968 Fax: (614) 210-0822

Hours: M,T,Th: 8:30AM-5:30 PM W: 8:30AM-6PM F: 8:30AM-2PM Closed for Lunch: M-Th 12:30PM-1PM