Family Drug Treatment Court

SNOHOMISH COUNTY
FAMILY DRUG TREATMENT COURT
Judge Janice E. Ellis
Edmund H. Smith, Coordinator
(425) 388-7887

THIS COMPLETED FORM MUST BE FAXED BY THE HEALTHCARE PROVIDER DIRECTLY TO THE DRUG COURT COORDINATOR AT (425) 388-7882 WITHIN 24 HRS OF THE ISSUANCE OF THE PRESCRIPTION.

MEDICATION FORM

This Client has been diagnosed with a substance-related and addictive disorder and is participating in chemical dependency treatment through Snohomish County's Family Drug Treatment Court (FDTC). **As part of this Client's treatment and participation in FDTC, they must avoid medications that may be habit forming, have abuse potential and/or may be harmful to their recovery. Examples include but not limited to:**

- **Central Nervous System (CNS) Stimulates** (e.g. Adderall, Concerta, Ritalin, Dexedrine)
- **Barbiturates** (e.g. Seconol, Butisol Sodium, Phenobarbital)
- **Benzodiazepines** (e.g. Xanax, Klonopin, Valium)
- **Hallucinogens** (e.g. Dextromethorphan-DXM, Cannabis, Marinol)
- **Sedative-Hypnotic** (e.g. Ambien, Soma, Lunesta)
- **Opioids** (e.g. OxyContin, Vicodin, Codeine, Suboxone, Methadone, Tramadol)
- **Over the Counter Medications** including pseudoephrine, ephedrine, dextromethorphan, phenylephrine, alcohol, or medication that may conflict with urinalysis testing (e.g. Nyquil, Sudafed, Robitussin)

***Please recommend or prescribe alternative treatment or medications from the above list**

If you believe it is a **medical necessity** to prescribe this Client any pain/other medication that has the potential for abuse or to become habit forming, **please prescribe such medications for the shortest duration possible.**

The Drug Court Team reserves the right to review Participants program eligibility based upon any and all prescribed medications.

Note: ***Except in the event of a medical emergency, this form must be completed and turned in to the Drug Court Coordinator prior to taking the medication.***

Health Care Provider

To be completed by Health Care Provider:

1. Client Name: _____

2. The **CURRENT DIAGNOSIS** is:

_____ _____
Diagnosis Date of Onset

_____ _____ _____
Medication Dosage Length of time client is to remain on this medication (days, weeks, months)

_____
Intended purpose

_____ _____
Physician signature Date signed

_____ _____
Printed name of physician/health care provider Phone number

HEALTH CARE PROVIDER: PLEASE ATTACH BUSINESS CARD