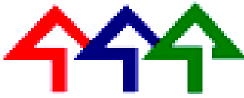

Snohomish County District Court

MENTAL HEALTH THERAPEUTIC COURT

ANTHONY E. HOWARD
JUDGE
DEPT. 3

EVERETT DIVISION
M/S #508
3000 Rockefeller Avenue
Everett, WA 98201-4046

MHC PROGRAM COORDINATOR
Shamora Bearwood
(425) 388-3085
MHC SPECIALTY COURT OFFICER
Rebecca Partington
(425) 262-2439
Fax (425) 388-6397

Medication Form

THIS COMPLETED FORM MUST BE SUBMITTED WITHIN 48 HOURS AFTER PRESCRIBING ANY MEDICATIONS ON THIS LIST.

PLEASE COMPLETE FOR ALL MEDICATIONS, WHETHER PRESCRIBED AND/OR ADMINISTERED DURING THE APPOINTMENT.

This individual has been diagnosed with a mental health and/or substance use-related addictive disorder and is participating in mental health and/or substance abuse treatment through Snohomish County's Mental Health Therapeutic Court (MHC). **As part of this client's treatment and participation in MHC, they need to avoid medications that may be habit forming, have abuse potential and/or may be harmful to their recovery. Examples include but are not limited to:**

- **Central Nervous System (CNS) Stimulants** (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, Tramadol)
- **Alcohol** (e.g. Peridex Oral Rinse)
- **Over the Counter Medications** including pseudoephedrine, ephedrine, dextromethorphan, phenylephrine, alcohol, or medication that may conflict with urinalysis testing (e.g. Nyquil, Sudafed, Robitussin, Delsym, Vicks, Claritin-D, Benadryl, Zantac)

***Please recommend or prescribe alternative treatment or medications that are not in categories included on the above list if at all possible.**

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

The Mental Health Court reserves the right to review client's program eligibility based upon any and all prescribed medications.

Snohomish County District Court

MENTAL HEALTH THERAPEUTIC COURT

To be completed by Health Care Provider:

List all medications of any type currently prescribed to this client and/or any over-the-counter medications that are currently recommended to the client, whether or not they are included in the list on the previous page. Please use additional page(s) if necessary.

Client Name: ____

Diagnosis/medication 1:

____ ______________
Diagnosis Date of Onset

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

____
Intended purpose

Diagnosis/medication 2:

____ ______________
Diagnosis Date of Onset

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

____
Intended purpose

Diagnosis/medication 3:

____ ______________
Diagnosis Date of Onset

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

____
Intended purpose

Diagnosis/medication 4:

____ ______________
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