ISLAND COUNTY SUPERIOR COURT

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THIS COMPLETED FORM MUST BE FAXED BY THE HEALTHCARE PROVIDER DIRECTLY TO THE DRUG COURT AT 360-678-2139

Island County Drug Court
MEDICATION FORM

1. I have been diagnosed as an "addict" or "substance abusing", and I am participating in chemical dependency treatment and Island County Drug Court.

As part of my treatment, I need to avoid the following drugs, such as:

- **Narcotic Analgesics** (e.g. Vicodin, Percoset, Hydrocodone), **Sedative Hypnotics** (inc. benzodiazepines and barbiturates), **Tramadol/Ultram**, **Muscle Relaxants**, **Mood Altering Drugs**, **Any medication with the potential of being habit-forming**, **Prescription or over-the-counter stimulants** (including ephedrine, pseudo-ephedrine, etc.)

PLEASE RECOMMEND OR PRESCRIBE ALTERNATIVES FOR ME.

2 I must submit to regular urinalysis testing, and I am not permitted to use any prescribed medications except under the direct supervision of a physician.

3. If you believe it is **a medical necessity** to prescribe me any pain medication, mood altering drug or any medication with a potential to become habit-forming, please complete this form. **Please prescribe such medications for the shortest duration possible**. I will then submit it to drug court.

Note: ***Except in the event of a medical emergency, please have this form completed and turned in to the drug court.*** The Drug Court Team reserves the right to deny entry to candidates or terminate participants who are taking legally prescribed mind and/or mood altering drugs.

Health Care Provider

CLIENT NAME_____ CURRENT DIAGNOSIS_____

I understand the patient is chemically dependent but I have nevertheless written a prescription for the following medication for the purpose indicated:

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

_____ _____
Physician signature | Date signed

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

I, as the patient receiving prescribed medications, understand the following:

- If lost or stolen, I will need to obtain a new prescription and have a new form completed.
- This prescription may ONLY be used for the current diagnosis and MAY NOT be used for any other purpose. If this or a new condition arises in the future, a new prescription and form are needed.
- Except in the event of an emergency, I may have prescriptions dispensed from ONE health care provider ONLY and ONE pharmacy ONLY.
- It is understood that I will utilize non-addictive pain management WHENEVER possible, and that I will not use any illegal drugs or drugs which have not been lawfully prescribed to me.
- ANY misuse of my prescription, failure to provide this form, or misuse or falsification of this form may result in sanctions and be grounds for termination from the Drug Court program.
- If I have remaining medication that I do not wish to take, I will bring it to Oak Harbor Police Department or the Island County Sheriff's Office for destruction.

_____ _____
Participant Signature | Date