Superior Court of the State of Washington
for Snohomish County

SNOHOMISH COUNTY
FAMILY DRUG TREATMENT COURT
Judge Kenneth L. Cowsert
Edmund Smith, Coordinator
(425) 388-3486

FAMILY DRUG TREATMENT COURT MEDICATION FORM

Family Drug Treatment Court candidates and participants are only allowed to take prescribed mind and mood altering medications under the direct supervision of a physician. Physicians need to complete this form and it must be presented to the Drug Court Team **within 24 hours of the issuance of the prescription.**

Note: The FDTC Team reserves the right to deny entry to candidates or terminate participants who are taking legally prescribed mind and/or mood altering drugs on the grounds that drug testing results are rendered unreliable by such medications, and hence FDTC participation is not practical for such individuals.

Health Care Provider

I was informed by my patient, ____, on ______________ that s/he has been currently diagnosed as "substance dependent" and is participating in chemical dependency treatment in the Snohomish County Family Drug Treatment Court Program. The goal of the treatment program is to help participants achieve and maintain alcohol-and other drug-free lives, including from all mind and mood altering drugs.

1. The current diagnosis is:

____ ____________________

Diagnosis — Date of Onset

2. In my opinion, the medical reason for the prescribed prescription for this diagnosis is:

____

Medical Reason

3. I understand the expectation of Drug Treatment Court is that the patient will not utilize any mind and mood altering drugs. The prescription for this client is:

_____________________ ______ ____

Prescription — 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

HEALTH CARE PROVIDER: **PLEASE ATTACH A COPY OF YOUR BUSINESS CARD**

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Participant signature required on the other side of this form

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

- This prescription MAY NOT be replaced if lost or stolen.
- This prescription may ONLY be used for the current diagnosis and MAY NOT be used for any other purpose or should the condition arise in the future (a new prescription and form are needed).
- I may have prescriptions dispensed from ONE health care provider ONLY and ONE pharmacy ONLY. In the event of an emergency, I will provide this form to the service provider immediately.
- The expectation of the FDTC Program is that I will utilize non-narcotic pain management WHENEVER possible, including no use of other banned medications.
- 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 FDTC Program.

____ ____________________

Participant Signature Date

PARTICIPANT: PLEASE BE SURE THIS COMPLETED FORM IS FAXED OR DELIVERED TO LAURA HELLSTROM c/o EVERGREEN MANOR WITHIN 24 HRS FROM THE TIME THE *PRESCRIPTION IS ISSUED*.

THANK YOU

FAX / ADDRESS INFO:

LAURA HELLSTROM, FDTC TREATMENT LIAISON
c/o EVERGREEN MANOR, INC.
Everett (North)
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Everett, WA 98201

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