



Superior Court of the State of Washington for Snohomish County

SNOHOMISH COUNTY ADULT DRUG TREATMENT COURT

MARYBETH DINGLEDY JUDGE DEPT. 5

SNOHOMISH COUNTY COURTHOUSE M/S #502 3000 Rockefeller Avenue Everett, WA 98201-4060

DRUG COURT COORDINATOR Laura Whitaker (425) 388-3093 Katie Shiner (425) 388-3546 Fax (425) 388-3597

Medication Form

THIS COMPLETED FORM MUST BE SUBMITTED WITHIN 48 HOURS AFTER RECEIVING THE MEDICATION.

PLEASE COMPLETE FOR ALL MEDICATIONS - PRESCRIBED AND/OR ADMINISTERED DURING THE APPOINTMENT

This client has been diagnosed with a substance-related and addictive disorder and is participating in substance abuse treatment through Snohomish County's Adult Drug Treatment Court (ADTC). As part of this client's treatment and participation in ADTC, they must avoid medications that are highly addictive, including 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)
Sedative-Hypnotic (e.g. Ambien, Soma, Lunesta)
Opioids (e.g. OxyContin, Vicodin, Codeine, Tramadol, Fentanyl)
Alcohol (e.g. Peridex Oral Rinse)
Muscle Relaxants (e.g. Methocarbomal, Cyclobenzaprine)
Cannabinoids (e.g. Marinol, CBD)

*Please recommend or prescribe alternative treatment or medications from the above list. If this client is given a take home prescription for any of the above medications, their status in drug court will be impacted.

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 client's program eligibility based upon any and all prescribed medications.

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 _____