



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  
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## **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)
- **Cannabidiol (CBD, THC, Marijuana)**
- **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.

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**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