Medical/Dental Medication Form

MEDICAL FACILITY / CLINIC

PHYSICIAN'S NAME (PLEASE PRINT)

STREET ADDRESS CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER

This notification is to inform you that

_____

NAME OF PIERCE COUNTY DISTRICT COURT PARTICIPANT

Is currently a Pierce County District Court Veterans Treatment Court participant and is a recovering addict/alcoholic. As part of a structured, judicially supervised treatment program, the Veterans Treatment Court participants are frequently subjected to random drug testing. ***Therefore, all medications and treatment procedures should be prescribed with this information in mind.***

Diagnosis/Treatment: _____

Prescription: _____

PLEASE SPECIFY MEDICATION TYPE AND DOSAGE

Prescription: _____

PLEASE SPECIFY MEDICATION TYPE AND DOSAGE

Prescription: _____

PLEASE SPECIFY MEDICATION TYPE AND DOSAGE

SIGNATURE OF PHYSICIAN _____ DATE_____