MEDICATION REQUEST FORM

Participant Name:_______________________________ Date of Birth:_________________

All requests to take a medication must be made by filling out this form. No participant shall begin using a medication prior to approval from the Drug Accountability Program. No participant will be given permission to take a medication that will react or cross-react with drug testing unless the program coordinator determines it appropriate for the participant to do so. There is one and only one exception to this rule. The exception is in cases of a true medical emergency situation.

TO BE COMPLETED BY TREATING PHYSICIAN

I acknowledge that the above named individual has revealed that they are a substance user and that they are currently enrolled in the Seward County Drug Accountability Program. I believe that prescribing the medication as listed below is the best course of treatment.

Medication Name: _____________________________ Strength:___________________
Frequency:___________________________________Quantity:___________________
Start Date:_______________Refills:_______________ Duration: __________________
Preferred Pharmacy:____________________________ Pharmacy Phone:____________
Reason for Prescription: ____
Physician Name:____
Physician's Phone Number:____

Physician Signature:___________________________________ Date:_____________________

TO BE COMPLETED BY PARTICIPANT

By signing below, I acknowledge the following:

1. All the information I have provided on this form is true.
2. I have read and understand this form as well as the conditions outlined in my Drug Accountability Program Handbook pertaining to the use of medications.
3. I will take approved medications only as prescribed or directed by the treating physician.
4. I will not begin using a medication prior to receiving approval from the Drug Accountability Program staff.
5. If the medications I have been given permission to take begin to interfere with my drug testing in any way, I shall discontinue the use of the medication.
6. If I have to discontinue the use of a medication, I shall complete a new Medication Request Form prior to beginning any new medication.

Participant's Signature:__________________________________ Date:_____________________

FOR OFFICE USE ONLY

Type of Condition: ☐ Mental ☐ Physical

Request Granted: ☐ Yes ☐ No

Drug Program Staff Signature: Date:

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