Douglas County DUI/Drug Court

DUI/Drug Court Director:
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Notice to Medical Professional

RE: _____

Dear Medical Professional,

Please be advised that the above referenced patient is a Participant in the Douglas County DUI/Drug Court Program. Admission to this program is based on a current diagnosis of Substance Abuse/or Dependence, as defined in the DSM-V.

Participants are required to inform all medical professionals, from whom they may receive treatment, of their involvement in drug and alcohol treatment. Our protocol also requires Participants to disclose past drug abuse patterns and provide documentation verifying this notice to medical professionals.

We request that our Participant's sensitivity to drugs of abuse be considered when you prescribe medications or injections in their treatment. We also ask you to consider these additional factors:

1. Potential increased tolerance to pain killer medications, due to the Participant's potential of past drug abuse of these medication;
2. Use of non-narcotic pain relievers;
3. Limiting the quantity of narcotic pain relievers to the minimum necessary (less than 15);
4. Limiting the number of refills available (none);
5. Recommending non-medicinal coping strategies for anxiety/ sleep issues in lieu of prescribing Xanax, Valium, Ativan, Halcion, Deseryl, Ambien, etc.

While it is not the intent of our program to have our Participants needlessly suffer pain, we feel that close communication between them and their medical providers is a key component in their achievement of stabilized recovery.

All of our Participants have been given a handbook of medications to avoid and medications that are approved. It is our hope that you will review this guide with the Participant and work together to come up with a solution.

We appreciate your consideration and cooperation in this matter. Please contact me if you have any further questions.

Sincerely,

Anita Grainger

DUI/Drug Court Director

I have read the above Notice to Medical Professionals. This letter was presented to me:

☐ before treatment was given ☐ after treatment was given

Physician's address

Physician's phone number

Physician's printed name

Date

Physician's signature

Date

PLEASE HAVE PHYSICIAN FAX COMPLETED FORM TO THE NUMBER ABOVE