King County

KING COUNTY DRUG DIVERSION COURT SERVICES

516 Third Avenue, Room E-609
Seattle, WA 98104
(206) 477-0788 – Fax: (206) 296-7885

PRESCRIPTION DRUG USE FORM

Date: _____

Name of Patient: _____

Physician's Name: _____

Address: _____

_____

Phone: _____

The above named individual has been charged with a Drug Related Felony.

S/He is currently participating in the King County Drug Diversion Court treatment program. The general policy of Drug Court is that use of a controlled substance is not acceptable while participating in this program. The Court permits limited exceptions to this policy based upon medical necessity.

This document attests that the above named patient has been diagnosed with a physical or mental health condition that requires the use of prescribed medication.

Please identify the medical condition that requires this prescription: _____

_____

Identify the medication prescribed: _____

Date of Prescription: _____

Quantity: _____ **Number of Refills allowed:** _____

How long do you anticipate the medication will be used? _____

_____

_____
Prescribing Physician/ARNP Signature

The patient is to provide a copy of this form to both the Chemical Dependency Counselor **AND the Court.