ADULT DRUG COURT
MACOMB COUNTY

MEDICAL/DENTAL/MEDICATION FORM

From:_____
(Medical Facility/Clinic)

_____
(Physician's Name)

_____
(Address, Including City, State, Zip)

_____
(Telephone) (Fax)

This notification is to inform you that _____ is currently a Macomb County Drug Court Participant and is in recovery from substance abuse and or addiction. The use of **ANY** mood altering chemical and / or controlled substance could be detrimental to his/her recovery and health. **It is extremely important to use non-narcotic, non-mood-altering medication whenever possible in this individual's medical care.** If a prescription of any kind is necessary, please provide the below information. If no prescription was written, please indicate below and sign to acknowledge receipt of this information.

Diagnosis/Treatment: _____
(Please Print)

☐ No prescription was written

Prescription: _____ Medication Type: _____ Dosage: _____

Prescription: _____ Medication Type: _____ Dosage: _____

Prescription: _____ Medication Type: _____ Dosage: _____

_____ _____
(Date) (Signature)

*This form is to be returned by the participant to the Program Coordinator.

Macomb County Circuit Court
40 N. Main Street, Mount Clemens, MI 48043
(586) 469-5016