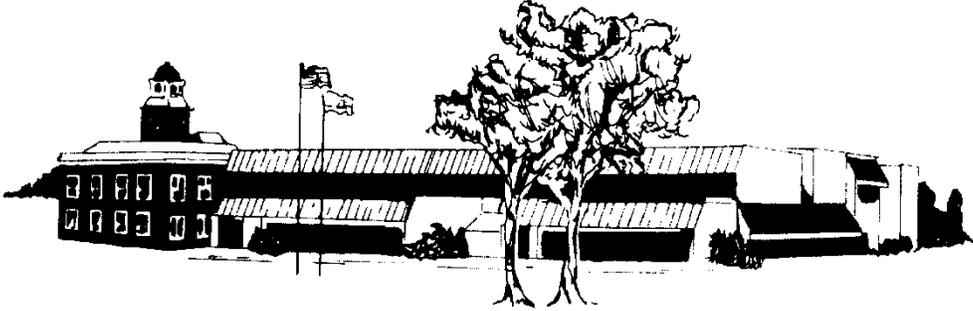


**CLALLAM COUNTY  
DRUG COURT**



COURTHOUSE  
223 East Fourth Street, Suite 8  
Port Angeles, WA 98362-3015

Johnny Watts  
Clallam County  
Drug Court Coordinator  
(360) 417-2549  
(360) 417-2204 Fax

Your patient is currently participating in the Clallam County Drug Court program. Your patient has been diagnosed with a Substance Use Disorder and is currently receiving Substance Abuse Treatment. As part of the Drug Court program, in cases of medical emergency your patient must provide documentation to the Drug Court Coordinator and Substance Abuse Treatment provider within 48 hours if they are prescribed any pain medication, muscle relaxants, stimulants, anxiety medications or any other mood altering medication. If it is not a medical emergency, all mood altering medications should be coordinated with their primary Substance Abuse Treatment Provider as well as the Drug Court Coordinator prior to administration of the medication and documented. As you know, all of these medications can complicate the treatment and recovery of Substance Use Disorders. If at all possible we would ask they be given an alternative medication, but we know this is not possible in all cases. In an effort to support the client in the recovery process we require frequent drug testing and monitoring of the DEA database to ensure the client is not seeking medication from multiple physicians. Unless the documentation below is faxed to us, any positive drug test will result in a sanction for the client up to and including incarceration. Therefore we would ask that you please fax the following information to both the Clallam County Drug Court Coordinator and the associated Substance Abuse Treatment Provider. Please ensure the proper releases of information are provided and coordination of care is well-documented.

**Patient Name:** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_

**Diagnosis & Code(s):** \_\_\_\_\_

**Medication(s) prescribed:** \_\_\_\_\_ **Dosage(s):** \_\_\_\_\_

**Prognosis & length of treatment:** \_\_\_\_\_

**Name and address of agency:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Physician Name (please print):** \_\_\_\_\_ **DEA #:** \_\_\_\_\_

**Physician signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_