MACOMB COUNTY DWI/SOBRIETY TREATMENT COURT
MEDICAL/DENTAL/MEDICATION FORM

This notification is to inform you that:

_____

is currently a Macomb County DWI/Sobriety Treatment Court (MC DWI STC) Participant and is in recovery from substance abuse and or addiction. The use of **ANY** mood altering chemical, and/or habit forming controlled substance could be detrimental to his/her recovery and health. **It is extremely important to use non-narcotic, non-mood-altering and non-habit forming 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 for: _____
(Please Print)

☐ **No prescription was written**

The following prescription(s) are necessary:

Prescription: _____ Dosage: _____

Prescription: _____ Dosage: _____

Prescription: _____ Dosage: _____

Prescription: _____ Dosage: _____

Medical Office Name: _____

Phone Number: _____ Fax Number: _____

Physician Name: _____

_____ _____
(Date) ***(Physician's Signature)***

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