Forsyth County Accountability Courts

Physician Form – Notice to Medical Professionals

This COMPLETED form must be FAXED by the physician to the Accountability Courts Office at (678) 455-4781

Participant/Patient Name: _____

Program: ☐ C.A.R.E Court ☐ Drug Court ☐ DUI Court ☐ Family Treatment Court

Dear Medical Professional,

Please be advised the above referenced patient is a participant in the Forsyth County Accountability Courts Program. Participation in this program is based on an admission of substance abuse or dependence coupled with clinical impressions.

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

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

1. Potential increased tolerance to pain reliever medications, due to the participant's potential past drug abuse of these medications;
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 (alprazolam), Valium (diazepam), Ativan (lorazepam), Klonopin (clonazepam), Deseryl (trazodone), Ambien (zolpidem), etc.

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

We appreciate your consideration and cooperation in this matter. Please contact the Accountability Courts Office at 678-455-4780 if you have any questions.

Sincerely,

Forsyth County Accountability Courts

I have read the above Notice to Medical Professionals. This letter was presented to me:
☐ before treatment was given ☐ after treatment was given

Were any medication(s) administered at the visit today? ☐ No ☐ Yes

If Yes, what medication(s)? _____

Were any new medication(s) prescribed today? ☐ No ☐ Yes

If Yes, what medication(s)? _____

_____

Physician Name (Printed) **Name of Practice/Phone number**

_____

Physician's signature **Date**