22nd Judicial District Court
SOBRIETY COURT Treatment Program
701 N. Columbia Street
Covington, LA 70433
Phone: (985) 288-5771 Fax: (985) 288-5773

Date: __________

Dear Healthcare Provider,

My name is _________________________ and I am currently enrolled in the 22nd JDC Sobriety Court Program. My Case Manager's name is _________________. Because of my participation in this program, I am required to present this letter to you so that you know about my history of **Substance Abuse and/or Dependence**. One condition of my participation in the program is that I can only take **MOOD ALTERING MEDICATION** if it is the **ONLY** way my health care provider can treat my condition.

If you find it absolutely necessary to prescribe any medication, I am required to have you fill out the following information and fax it to the Sobriety/Drug Court office **immediately.** Thank You for your assistance in this matter. **(PLEASE PRINT)**

Patient's Name: ____

Patient's Chief Complaint: ____________________________________

Name of Medication Prescribed: ________________________________

Dosage and Frequency Prescribed: ______________________________

Amount Prescribed: ____________________ **Refills:** ___________________

Will medication cause any false (+) on a UDS? If yes, for what? ____________

Name of Physician: ____

Physician's Phone Number: ___________________________________

Signature of Physician: ______________________________________

Please fax this form to (985) 288-5773 immediately, ATTN: __________________.
Thank you again for your assistance in this matter.

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Participant Signature