

Prescription Drug Waiver Form

I, _____, understand that _____
Physician or APRN's Name Participant's Name
is a participant in the Uintah County Drug Court Program and has been diagnosed with a drug dependency problem. I understand that certain classes of drugs have a high potential for abuse and that certain classes of drugs (hypnotics, sedatives, anxiolytics, opiates/opioids, and stimulants) in many circumstance may not be appropriate for addicts whose drug(s) dependence is not in remission or is still in early remission.

_____ drug(s) of choice is(are) _____
Participant's Name Participant's Drug(s) of Choice
_____.

I understand that it is common for people who are drug dependant to substitute other classes of drugs when they do not have access to their drug of choice. I am prescribing

_____. I anticipate that _____
Medication and dosage Participant's Name
_____ will be on this medication for _____
of days, weeks or months

Physician or APRN Signature and Date

Drug Court Participant Signature and Date

If the prescribing physician or APRN has any questions about this form, they may contact Northeastern Counseling Center at (435) 789-6300. NCC is not able to release any information without a release of information that is compliant with 42 CFR 2.