Dear Health Care Provider:

__________________________________________ is a participant in the Veritas Intensive Supervision/Drug Treatment Program run by the Bristol Virginia Circuit Court. The above named was selected for participation in Veritas after a Substance Abuse/Dependence diagnosis was made by a mental health professional.

If there is any way possible, we ask that this patient be treated with non-narcotic, non-addictive medications. We also ask that you assist us in monitoring any and all medications to be taken by this patient. The patient is drug tested frequently by Veritas and all medications of any kind are counted to monitor compliance. He or she will not be allowed to take any prescribed medications unless you sign below and complete the requested information.

Thanks very much for your cooperation. Please give me a call any time, weekends included if you have any questions.

Respectfully,

Susan C. Morrow
Program Coordinator

I, ______________________________________ have read the above. I have determined that the above patient will require the following medication(s) in the dosage(s) listed:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Signature ___________________________ Date

Contact Information: ____________________________________________