HEALTH CARE PROVIDER CARD

****** ATTENTION ****** **HEALTH CARE PROVIDER** I am recovering from chemical dependency and am a participant in the Clatsop County Adult Drug Court Program. I am required to inform you that I am prohibited from taking medications from the following groups because they pose a significant risk to my recovery. *** Benzodiazepines**Amphetamines* *Cannabinoids* *Opiates* *Alcohol* *Ephedrine*** Please do not prescribe me medication from the above categories unless it is medically necessary. Please **sign the reverse side of this card** to acknowledge that I have shown you this statement.	Medication_____Quantity_____ Reason medication was prescribed_____ _____ _____ _____ _____ _____ Prescriber Signature Date *Participants must provide this signed card **with copy of prescription** to the Adult Drug Court treatment provider and Community Corrections within **24 hours** of receiving any prescription NOTE: If received on the weekend, turn in by **5:00 p.m. on Monday**)