State Court of Fulton County
DUI Treatment Court Program

Prescription Medication Change

Name: _____ Date: _____

Name of Medication: _____

If this is a **new medication**, complete this section:

Reason medication is being prescribed: _____

_____

Frequency: _____ How administered (oral, patch, etc.): _____

Prescribing physician: _____

Physician's phone number: _____

If this is a **medication change**, complete this section:

Reason for proposed change: _____

_____

Proposed change: _____

Prescribing physician: _____

Physician's phone number: _____

When are you supposed to start/change this medication? _____

By signing your name below, you are certifying to the Court that all of the above information is correct and that you have not stopped, started, or change any medications. If this may cause a positive drug screen, a medication log will be required. This information will be kept in confidential files. This form must be turned in to the DU Treatment Court before you get the prescription filled and/or take the medication.

_____ _____
Participant Signature Date

Approved (Yes or No) _____ Date Participant Informed _____ How Informed _____

Comments _____

_____ _____
Court Staff Date

Updated: July 22, 2019