Griffin Circuit Drug/Alcohol Accountability Court; Intensive Supervision & Treatment

Genna Marie Morris, Court Treatment Coordinator
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Dear Health Care Provider:
(Client Name):_____(DOB)_____is a participant in the Intensive Supervision/Drug Treatment Program run by the Griffin Circuit Accountability Court. This patient is seeking:

- ☐ To become a new/ongoing patient of your practice for basic physical healthcare
- ☐ To become a new/ongoing patient of your practice for behavioral/emotional healthcare
- ☐ A standard physical
- ☐ A behavioral health/addiction intake required to see your psychiatrist for potential medication needs
- ☐ Lab Screening/Testing including: _____
- ☐ Coordination of Care for a necessary or preferred medical procedure
- ☐ Other:_____

This client receives clinical group/individual therapy outpatient care, random urine screens, supervision and case management in our program.
In the interest of the client's freedom, health and wellness, this client must be treated with **non- narcotic, non-addictive** medications when needed. **All medical procedures must be approved by the court.** We require coordination of care with all doctor(s) and services. The participant is drug tested frequently by Choice Labs and all medications of any kind are counted/assessed to monitor compliance. **Participants will not be allowed to take any prescribed medications or schedule medical procedures without your information below.** If the client is recommended for medication(s) banned by this judicial circuit, alternatives will need to be recommended and approved. Please consider the fragility of recovery and stability with all medical decisions. **This client may not fill or take a medication without prior approval. Participants must provide all documentation of each medical visit to their court case manager upon completion of appointment.** Please give me a call anytime for collaboration.
Respectfully,
Genna Marie Morris, MS, NCC, MATS, LPC, MAC

CLINICIAN Name: _____Clinician License Info:_____

I have read the above statement. I have attached the recommended procedure/medication/plan for this patient.

Clinician Signature:_____Date:_____

Phone: _____Fax:_____ Email:_____

CLIENT Compliance Statement: I have represented my physical, emotional and recovery health details with full disclosure and honesty to my clinician. I agree to follow the recommendations of the doctor faithfully if approved by the court.

Signature: _____Date: _____

Court Staff Only:
Treatment Staff Comments:

Signature: _____Date:_____

Lab Staff Comments:

Signature: _____Date:_____

Additional Clinician/Physician Coordination Info:

Signature: _____Date:_____