MEDICAL NOTIFICATION FORM

TO BE GIVEN TO THE TREATING HEALTH CARE PROFESSIONAL

I, _____, am currently a client with Maine Pretrial Services. I am a recovering drug addict and/or alcoholic. As a condition of my participation with Maine Pretrial Services, I submit to regular screenings to determine whether I have ingested alcohol, marijuana, barbiturates, benzodiazepines, opiates, narcotics, amphetamines, methamphetamines, hallucinogens, ephedrine, pseudoephedrine, and phenylpropanolamine (PPA). If I test "positive" for any of those substances, I may face a sanction, which may include termination from the program.

In order to avoid those consequences, I do not wish to unknowingly ingest any medication that might result in a positive test. If it is possible to appropriately treat my complaints or conditions with a medication that would not be considered alcohol, marijuana, barbiturates, benzodiazepines, opiates, narcotics, amphetamines, methamphetamines, hallucinogens, ephedrine, pseudoephedrine, and phenylpropanolamine (PPA) that would be my strong preference. If you believe it necessary to treat my complaints or conditions with a medication above, please tell me so that I can make an informed choice.

Please feel free to access Mainepretrial.org for the location nearest you if you have any questions or concerns.

TO BE RETURNED TO THE MAINE PRETRIAL CASE MANAGER

I, _____, (health care provider's name) provided medical treatment to_____(patient) on _____(date).

I hereby verify that the patient provided me with a copy of the Maine Pretrial Services Medical Notification Form.

_____ I have not prescribed or suggested any medication containing alcohol, marijuana, barbiturates, benzodiazepines, opiates, narcotics, amphetamines, methamphetamines, hallucinogens, ephedrine, pseudoephedrine, and phenylpropanolamine (PPA).

_____ I believe it medically necessary to prescribe or suggest and have prescribed or suggested a medication containing alcohol, marijuana, barbiturates, benzodiazepines, opiates, narcotics, amphetamines, methamphetamines, hallucinogens, ephedrine, pseudoephedrine, and phenylpropanolamine (PPA) for the following medical complaints or conditions:

_____. I anticipate such medications will be necessary for _____(days, weeks, months).

_____ _____

Healthcare Provider's Signature Date

_____ _____

Printed Name of Provider Office Name, Telephone & Fax Number