Physician Form
Notice to Medical Professionals

This COMPLETED form must be EMAILED by the physician to the Veterans Treatment Court Office at laurenm@hamiltontn.gov

Participant/Patient Name: _____ Date: _____

Dear Medical Professional,

Please be advised the above referenced patient is a participant in the Hamilton County Veterans Treatment Court Program. Participation in this program is based in part on an admission of substance abuse or dependence coupled with clinical impressions.
Participants should inform all medical professionals, from whom they may receive treatment, of their involvement in drug and alcohol treatment and disclose past alcohol and drug abuse patterns. Participants are required to provide documentation to Veterans Treatment Court verifying this notice to medical professionals.

We request that our participant's sensitivity to drugs of abuse be considered when you prescribe prescriptions or injections in their treatment. We ask you to consider these additional factors:

1. Potential increased tolerance to pain reliever medications, due to the participant's potential past drug abuse of these medications;
2. Use of non-narcotic pain relievers;
3. Limiting the quantity of narcotic pain relievers to the minimum necessary (less than 15);
4. Limiting the number of refills available (none);
5. Recommending non-medicinal coping strategies for anxiety/sleep issues in lieu of prescribing medications known to be addictive or misused.

While it is not the intent of our program to have our participants needlessly suffer pain, we believe close communication between them and their medical providers is a key component in their achievement of stabilized recovery.
We appreciate your consideration and cooperation in this matter. Please contact the Hamilton County Veterans Treatment Court at 423-994-5967 if you have any questions.

Sincerely,
Hamilton County Veterans Treatment Court

I have read the above Notice to Medical Professionals. This letter was presented to me:
☐ before treatment was given ☐ after treatment was given

Were any medication(s) administered at the visit today? ☐ No ☐ Yes
If Yes, what medication(s)?_____
_____

Were any new medication(s) prescribed today? ☐ No ☐ Yes
If Yes, what medication(s)?_____
_____

_____ _____
Physician Name (Printed) Name of Practice/Phone number