AOC-SPC-73
Rev. 3-23

Commonwealth of Kentucky
Court of Justice *www.kycourts.gov*

MEDICAL APPOINTMENT VERIFICATION

_____ District/Circuit Court
Criminal Branch
_____ Division
Specialty Court

Medical Appointment Date: _____, 2_____

Name of Facility: _____

Address: _____

_____

Phone: (____)_____

Medical staff seen: _____

I, _____, am a participant in the _____ County Specialty Court Program. The program is a court monitored program for persons with substance use disorders. I am subject to frequent and random drug testing and respectfully request that you consider this when medications are necessary for my medical treatment.

Please list the reason for today's visit/diagnosis (*please print*).

_____

Please list **ALL** medications and refills prescribed/administered today. Please include medication name, dosage and quantity given *(please print)*.

_____

_____

_____

_____

Follow up appointments/recommendations:

_____

_____

Medical Staff Signature: _____

Please Fax to: (____)_____ OR Scan/Email to: _____

If you have any questions or concerns, please contact Specialty Court staff at: (____)_____.

Print Form **Reset Form**