St. Clair County Community Mental Health Authority

Request for Transfer to an Alternate Prescriber

Individual:_____ Case #:_____ Date:_____

Program: _____

The request to transfer to an alternate prescriber is due to the following reasons:

I understand the alternate prescriber:

- May order a Urine Drug Screen (UDS) as part of my treatment.
- May alter, discontinue, or add diagnoses and/or medications to my treatment plan.
- May not prescribe any controlled substances including benzodiazepines (Ativan, Xanax, Klonopin, Restoril, Valium) and stimulants (Adderall).
- May only provide telehealth services.

_____	_____	_____
Case Holder Signature/Credentials	Printed Name	Date
_____	_____	_____
Supervisor Signature/Credentials	Printed Name	Date
_____	_____	_____
Individual Signature	Printed Name	Date
_____	_____	_____
Guardian Signature	Printed Name	Date