August 2019

UTAH RECOVERY ASSISTANCE PROGRAM RECOMMENDATION REPORT

Kelly Lundberg, PhD
Olivia Rhead, MHR

SCOPE

In February of 2019, the Department of Commerce Division of Occupational and Professional Licensing (DOPL) issued a Request for Proposal to evaluate the Utah Recovery Assistance Program (URAP). Both an Evaluation Report and a Recommendation report were solicited. The Evaluation Report was submitted to DOPL on July 16, 2019. The purpose of this Recommendation Report is to use all information, documentation, and data previously gathered to make recommendations for changes in the structure and processes of URAP.

METHODOLOGY

The methods and documents used in this Report include those mentioned in the Methodology Section of the Evaluation Report. In addition, the contract required that we communicate with at least ten other state programs. Regardless of adherence to best practices, all PHPs are very different. While attending the Federation of State Physician Health Programs (FSPHP) Conference, Dr. Lundberg spoke with the current president of FSPHP and the president-elect, as well as other PHP Directors to obtain their recommendations for exceptional programs. Several states came up consistently in conversations, and thus they comprise part of our list. They are: Georgia, Indiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, North Carolina, Tennessee, and West Virginia. While Washington also was mentioned numerous times, their program has an operating budget of over one million dollars and thus was eliminated. Iowa and Minnesota were also included since, with the exception of Utah, they appear to be the only remaining states which have PHPs that exist within the regulatory authority. Finally, a decision was made to include Idaho because it is similar to Utah in both population size and culture. The Executive Directors of all of these programs were subsequently contacted via email. We received immediate responses from 12 of them. Missouri did not respond to our email despite two attempts. Arrangements were made to speak with the Executive Directors over the phone with the goal of gathering information and data about their programs. These conversations lasted anywhere from 1 to 2 hours, and all individuals we spoke with were incredibly generous with their time and information. We have summarized the data in the attached Tables, as well as on a cover sheet representing each state's program. We also requested various forms and policies from many of these programs, and have included them in this report. Additionally, we have attached all forms and policies that were available on the program websites. Many programs were in the process of revising their forms, and not all programs were willing to provide them. Nonetheless we believe we have numerous examples that will be of great use as URAP is restructured.

In addition to the communication with the PHPs described above, we visited a regional meeting with participating pharmacists and nurses in Montana, which will be described below. It should be noted that most programs do not have formal meetings with their participants. Those that

do, Iowa and Idaho, had no meetings taking place during the contract period. Thus we did not visit other programs.

We have taken all of this information, worked in conjunction with DOPL staff, and have chosen elements and procedures from various programs from which to base our recommendations. We believe they represent the best of the best and can apply to Utah's PHP, which we will subsequently refer to as the Utah Professional Health Program (UPHP).

ORGANIZATION OF REPORT

The Report is organized into three primary sections. The first is the Recommendations section which outlines our recommendations for restructuring UPHP. The second is the Tables section which summarizes much of the data we obtained and provides a source of quick and easy comparisons across states. The third section comprises the State PHP Information Packets. This section contains information collected from each state's PHP, including a cover sheet summary, and the various forms or policies which were either provided or available on their website.

RECOMMENDATIONS

UPHP Staff and Structure

In order to effectively manage and administer the clinical and administrative functions, UPHP staff should include an Executive Director, a Medical Director, Case Managers**,** and a Program Manager. The Executive Director should be a psychologist or physician who has an expertise in addressing and treating substance use disorders as well as experience in administration. The Executive Director should also play a key role in education and outreach as outlined in our Evaluation Report and should serve as a liaison to the Boards. We recommend the Medical Director be Board-certified in addiction medicine or addiction psychiatry. Finally, we recommend that the Case Managers be master's level mental health therapists with an expertise in addressing and treating substance use disorders.

We also recommend that UPHP only serve licensees who fall under the category of physicians, nurses, and pharmacists. Specifically, this would include physicians, surgeons, osteopaths, nurses, advanced practice registered nurses**,** and pharmacists. We recognize that addiction affects all individuals, but securing the resources necessary to provide services to all licensees in a manner consistent with best practices, and in a manner which recognizes the inherent differences that exist across populations, would be challenging at best. Furthermore, we believe that serving the safety-sensitive professions is most consistent with DOPL's mission to

protect the public. These three populations also account for the majority of the substance related investigations DOPL received during 2017 and 2018 (see Attachment A).

With regards to the size of the program and number of employees, we believe this will be naturally dictated by the number of licensees the program will serve. The generally accepted lifetime prevalence of addiction among medical professionals is estimated to be 12%. When divided by a 30-year practice span, a point in time prevalence would be .4%. We obtained information that indicated PHPs typically generate a .8 to 1% penetration. If we extrapolate this data to include the professions of nursing and pharmacy**,** and we consider the number of individuals with an active license in Utah at the time of this report (although we recognize that not all of these individuals reside in Utah), we would expect UPHP to serve approximately 541 individuals at any given time.

	Active Licensees	Expected Number of Participants
MD/DO		
Physician & Surgeon	11,094	111
Osteopath Physician & Surgeon	1,185	12
Nursing		
APRN	2,827	28
Registered Nurse	34,667	350
Pharmacy		
Pharmacist	4,038	40
Total	53,811	541

Because it will take time to reach full penetration, we recommend UPHP initially hire a full time Executive Director, a part-time Medical Director, two full time Case Managers, and one Program Manager. Another alternative is that the Medical Director also serve as the Executive Director, in which case we would recommend hiring three full time Case Managers. The program, as well as the employees, should be members of FSPHP and attend the annual conference.

Should there be concerns about securing the necessary funding for UPHP, we recommend UPHP be limited to serving physicians only (estimated penetration of 123 participants) rather than compromising the integrity of the program. In this scenario only one Case Manager would be necessary and consultation with the Medical Director would not be needed as frequently.

We also recommend an Executive Committee or Board of Directors be established that provides a mechanism for direction, oversight**,** and accountability. PHPs establish memberships

for Executive Committees in various ways. We would suggest some members be nominated by the professional organizations and/or the DOPL board representing the professions served by UPHP. However, an individual should not concurrently serve on the Executive Committee and a Licensing Board. It is our opinion that the members need not receive monetary compensation.

In addition to an Executive Committee or Board, we also recommend the establishment of a Clinical Advisory Committee. This would be composed of a group of volunteers who are experts in the treatment of addiction. This Committee would meet on a predetermined basis and be available for consultation and assistance on specific cases, particularly those of a complex nature. The Committee would also serve as an entity for a participant to meet with when he or she would like to dispute the recommendations being made by UPHP. It should be noted that although FSPHP has not yet published their revised best practice guidelines, we have been informed that the establishment of a Clinical Advisory Committee will likely be part of those guidelines.

UPHP should only continue to exist within DOPL if UPHP staff have no other DOPL roles, UPHP is not located within the DOPL offices, and safe harbor is honored when participants voluntarily enter the Program and when they maintain compliance. Should this occur, we would recommend UPHP report to the Executive Committee rather than DOPL staff in order to further increase the separation of UPHP from DOPL. The Executive Committee would then meet with DOPL's Executive Director on a predetermined interval and submit an annual report and evaluation. An alternative would be for UPHP to exist elsewhere in the Department of Commerce.

It should be noted that most PHPs do not favor using a bid process to establish a PHP. They expressed numerous concerns about the quality of services, the qualifications of those who bid, and the motivation for profit. There have been some states who have contracted with the Department of Psychiatry at their local university. However, due to the numerous taxes levied within the institution, they have found the operating budgets become inadequate. The process that appears to work best is when the Medical Boards (and other professionals Boards) include language in statute indicating they shall establish a medical assistance program. This results in a great deal of latitude for how they establish a PHP and with whom. For those Medical Boards who wish to take a less active role in establishing a PHP, they can instead, with guidance, establish the Executive Board which will then take on this task**;** or assist in the hiring of the Executive Director who will then establish the structure of UPHP. We have included Montana's statute related to this in Attachment B. We have also included their statute regarding confidentiality of the program information.

Exclusion Criteria

The recommendations that we are proposing represent a complete change to the structure and process of the existing program. While the majority of PHPs monitor participants who struggle with other mental health issues, we are recommending that UPHP first focus solely on

substance use disorders. Most PHPs do not accept individuals with sexual boundary violations and we concur. We recommend that legal issues in and of themselves should not preclude participation in UPHP. However, arrests or convictions for sexual offenses, distribution of drugs, or similar offenses should be considered exclusion criteria. Some PHPs exclude individuals from participation who have harmed a patient, and we recommend UPHP do the same. Once UPHP has demonstrated and sustained success in both process and outcomes, they should reevaluate their exclusion criteria and their ability to monitor more complex cases.

It should be noted that many PHPs will indicate they have no exclusion criteria. While this may appear alarming at first glance, these PHPs are often monitoring individuals who are on probation. Professional Boards often find they simply do not have the expertise nor the resources to provide the intensive monitoring that a PHP is capable of. As a result, when those boards have a good, trusting relationship with their PHP, they typically prefer the PHP to provide the monitoring. Thus, just because an individual is on probation does not preclude their participation in a PHP, although it does mean they no longer have anonymity and safe harbor.

Intake and Assessment

The process of participating in a PHP should begin with a phone call or email to the PHP office and an immediate response from the PHP Executive Director. The two most common types of requests are those coming from the potential participant him or herself (voluntary or mandated), or from a concerned individual (e.g., a hospital chief of staff, a human resources employee, a colleague, a loved one, etc.). Procedures for addressing both of these requests are detailed below.

Contact from the Individual

As noted above, once a potential participant contacts UPHP, the Executive Director should respond quickly and establish a time to gather more information. Some programs do this exclusively over the phone and others require a face to face meeting. It is recommended that UPHP establish a policy that these meetings take place in person; however, UPHP should also allow for exceptions to this. For the purpose of this Report, we will refer to this meeting as an Intake Session. UPHP should avoid using the term 'assessment' to describe this process as there should be recognition that an assessment is a comprehensive, multidisciplinary process with specific requirements. Policies and procedures should outline the purpose of the Intake Session which should include, at minimum, providing information about UPHP, gathering information about the circumstances that led the individual to contact UPHP (including whether UPHP's Director has any obligation to report the information to the regulatory authority and whether the individual is suitable for the Program), and gathering enough clinical information regarding the potential substance use disorder that the Executive Director can determine the appropriate evaluation or referral.

Individuals who are deemed appropriate for participation in UPHP should be provided with, at minimum, a list of three approved agencies from which to choose where they can make arrangements for an assessment. The choices provided to the potential participant should be based on the Executive Director's clinical judgment and careful consideration of issues such as drug of choice, co-occurring disorders, financial means, age, gender, etc.

Consistent with best practices and subsequent recommendations identified in the Evaluation Report, agencies providing the assessment should be approved as an Addiction Treatment Program (ATP). It is recommended that UPHP develop a list of PHP-approved ATPs for physicians and recognize these will likely exist outside the state of Utah. We have included a list of agencies (Attachment C) that meet this requirement; however, this is not intended to be comprehensive. UPHP should create relationships with other PHPs that allow for sharing of information regarding the quality of ATPs. UPHP should also develop a list of assessment agencies within Utah that meet best practice guidelines, as established by the State, for the comprehensive assessment of substance use disorders for nurses and pharmacists (or, in some cases**,** physicians who are not deemed as needing an assessment that meets the more rigorous standard of an ATP). All assessments should include an evaluation of whether the individual can return to practice. Many PHPs (including Montana) provide statewide training in which agencies participate, with the goal of clarifying the critical and necessary elements of the assessment they would require. Some states, such as Tennessee, require those agencies to complete a form annually indicating they can abide by the PHP's requirements. Both Massachusetts' and Colorado's PHP have staff which conducts the assessments; however, this greatly increases budget costs and we do not recommend this for UPHP.

Once individuals have completed their assessments, the assessment is provided to UPHP which then begins monitoring the participants' adherence to the treatment recommendations as well as the additional requirements set forth by UPHP. Should an assessment recommend residential or inpatient treatment rather than outpatient treatment, monitoring would not commence until after completion of treatment.

Some PHPs have the individual sign the Monitoring Agreement at the time of the Intake Session, while others do not require a signature until the assessment or treatment has been completed. We have no strong recommendations regarding this and believe that the choice will become apparent as UPHP develops and outlines the details of their Program. However, we do recommend that all potential UPHP participants be informed that, should they disclose information about their potential addiction during the Intake Session**,** and then choose not to complete an evaluation or participate in UPHP, UPHP will provide all information gathered to the regulatory authority. An examples of an excellent Monitoring Agreement can be found in Georgia's PHP State Packet.

As discussed in the Evaluation Report, URAP requires all potential participants to meet with the staff from the Investigations Unit regardless of whether they contacted URAP voluntarily. We recommend eliminating this step for those individuals voluntarily seeking UPHP services. We

recognize this will be a difficult change, but there are numerous reasons for our recommendation.

First, meeting with the Investigations Unit is a deterrent against voluntarily entering the Program. As a result, the substance use disorder will likely go untreated and will subsequently worsen over time. This places the public at greater risk. Second, in our discussions with DOPL staff, it appears the requirement to meet with the Investigations Unit was implemented primarily as a result of longstanding distrust that existed between DOPL and URAP, due in part to concerns regarding transparency and consistency. Should UPHP implement our recommendations, there will actually be much more oversight of participants participating in UPHP than URAP provided. Additionally, there will be more oversight of UPHP participants than those with substance use disorders who are on probation. As you will see, this oversight includes immediate notification to the respective professional Board when an individual experiences a relapse or exhibits other serious noncompliance. This could result in being placed on probation and thus losing safe harbor (although this does not preclude UPHP from providing the monitoring). Third, the assessment process we are proposing is very comprehensive and includes obtaining collateral information from the employer. Thus any misconduct or criminal behavior that has occurred during the course of employment will be known and reported to DOPL consistent with statute. Fourth, we should keep in mind the high success rates of PHPs that follow recommended best practices. Specifically 78% to 81% of participants maintain abstinence five years following treatment.

Contact from Others

PHPs work to establish exceptional relationships with professional organizations, hospitals and other employers, and various stakeholders. They also provide education and outreach regarding substance use disorders to students, professionals, and the community. As such, UPHP's advice and counsel will be frequently solicited. UPHP should be aware of the statutes defining unprofessional conduct for all the professions they serve so they can provide accurate information regarding mandatory reporting to the regulatory authority. UPHP should be fully aware of the resources within Utah and the various options for services. UPHP should be prepared to provide guidance to employers, colleagues, and loved ones for how to initiate conversations with individuals for whom they are concerned. Finally, UPHP should have procedures in place regarding how to reach out to the individual who has been identified as having a potential substance use disorder with caring and compassion. While some UPHPs employ trained interventionists who conduct formal interventions at an individual's home or place of employment, we do not recommend that UPHP implement this service. This can always be revisited in the future.

The Use of Prescribed Controlled Substances and Marijuana

UPHP should have clear policies regarding the use of prescribed controlled substances and the requirements of abstinence, and the Evaluation Report made specific recommendations as to which of these should be included in the Monitoring Agreement. Georgia's PHP Monitoring Agreement, included in their Packet**,** has an excellent section regarding the requirements for abstinence and the use of potentially addicting prescribed medication. We would recommend incorporating their language; however, we also have provided specific recommendations regarding the use of other mood-altering substances.

As indicated in the Evaluation Report, it is not consistent with best practices to prescribe a sedative or benzodiazepine to individuals who have been diagnosed with a substance use disorder. Thus**,** it is recommended that UPHP exclude those individuals who wish to be prescribed medications that fall within these categories. That does not imply that UPHP should not attempt to educate individuals about the reasons for this contraindication. In fact, PHPs exist in part to promote health and wellness among safety-sensitive professions. Ideally, those individuals who come to the attention of UPHP should be educated and encouraged to work toward a complete, medically monitored taper before beginning their participation in UPHP.

Stimulants may be helpful for some individuals who suffer from Attention-Deficit Hyperactivity Disorder (ADHD) and have a concurrent substance use disorder. However, caution should still be applied. Most PHPs require an assessment from a physician who is Board-certified in either addiction medicine or addiction psychiatry. The documentation should include a diagnosis of ADHD, justification that the individual would benefit from a stimulant, and justification that the prescribed use of such a stimulant is necessary to optimally treat the co-occurring disorder. This is our recommendation as well.

PHPs generally recognize there are occasions that necessitate a short term prescription for a potentially addicting medication. A typical example would be a prescription for an opioid following surgery to effectively, yet temporarily, manage pain. We recommend employing the standard practice of PHPs in those situations. Specifically, individuals prescribed such medications must sign a nonpractice agreement and can only return to practice once they are no longer taking the medication. We also would recommend implementing North Carolina's requirement of not being able to return to practice until 24 hours after the last dose.

Few programs we spoke with have policies in place related to buprenorphine, primarily because most programs have not encountered situations in which individuals have not been tapered from buprenorphine prior to entering the PHP, or in which individuals have requested approval for a prescription to take buprenorphine. It is recommended this be evaluated on a case-by-case basis. Important considerations will include the history of compliance by the individual, whether the buprenorphine is intended to treat pain or a substance use disorder, and the primary drug of choice. UPHP will also need to consider whether they require a complete taper from buprenorphine before the participant is considered to have successfully completed the

program. In all cases there should be an evaluation from a physician who is Board-certified in either addiction medicine or addiction psychiatry which clearly documents the prescription is in the best interest of the patient to treat their condition and to assist in maintaining abstinence.

Six of the 12 PHPs we contacted exist in states that have legalized medical marijuana. None of these PHPs allows for the use of medical marijuana while participating in their program. The prevailing philosophy appears to be that should a physician or other professional need medical marijuana in order to treat their medical illness, they are likely not fit for practice due to that illness. Our recommendations mirror those of other states. The use of marijuana, regardless of its legality recreationally or medicinally, within the state of Utah or outside of the state of Utah, should not be allowed while participating in UPHP. DOPL should be vigilant to changes in statute or rule that would make this difficult to enforce. However, should this occur, the UPHP Monitoring Agreement should specifically state that an individual who tests positive for THC will be reported to the respective professional Board.

Participation Requirements

PHPs require compliance with all treatment recommendations and receive monthly or quarterly reports from the prospective provider. Examples of forms utilized for this purpose can be found in the State PHP Information Packets. In addition to these treatment requirements determined by the assessment, PHPs require other requirements after the participant has completed treatment or during participation in outpatient treatment. These vary widely across PHPs in part because they are tailored to the needs of the participant. For example, Montana's and West Virginia's PHPs require individuals with an alcohol disorder to attend 90 meetings in 90 days.

What does seem rather consistent is a minimum requirement of weekly participation in a caduceus meeting (or other type of peer meeting), and additional weekly participation in an abstinence based self-help meeting. Utah's options for caduceus meetings and peer meetings (which they refer to as Professionals in Recovery) have dwindled over the years. We recommend UPHP work with the Utah Medical Association to find physicians in recovery to volunteer to establish caduceus groups around the state of Utah with guidance from UPHP staff. Similarly, UPHP should work with the Utah Nursing Association and the Utah Pharmacy Association to establish similar groups, which can be combined to include participants from both professions.

Of note, Montana's PHP staff travel to different areas of the state on a quarterly basis to lead such groups. Their goal is for these groups to become self-sustaining and, once they achieve this goal, they intend to withdraw their participation. They recognize the sensitive discussions taking place within the groups should not necessarily be the purview of their PHP, however, they are balancing this with the need to establish peer support groups which become essential for a supportive recovery network for the participant. As indicated above, Dr. Lundberg observed a group which consisted of nurses and pharmacists. The group members shared their

poignant stories and their struggles, and provided encouragement and support to one another. Montana's PHP has found no difficulty integrating nurses with pharmacists in these peer groups. However, it has been more difficult to integrate nurses and pharmacists with the physicians. Only certain areas of Montana have been successful in maintaining all three professions in the same groups without some degree of rancor. We recommend UPHP begin by establishing caduceus groups for physicians, and peer groups for member of the pharmacy and nursing professions. We also recommend that Utah explore options for teleconferencing for those individuals who reside in remote areas.

Most PHPs allow the participant to choose the abstinence based self-help meeting that best works for their recovery philosophy. We agree with this; however, it is important that the meeting be abstinence based. While we would still encourage participation in meetings focused on other health and wellness issues, we believe these meetings should not meet the requirements of the program.

Some programs will decrease the requirement of weekly participation in both a caduceus/peer groups and an abstinence based self-help meeting after at least one year of compliant participation in the PHP. UPHP, like all PHPs, should consider recommendations from treatment as well as information regarding compliance to determine the frequency of these requirements. The Monitoring Agreement should make it clear that these requirements may be increased or decreased. However, we recommend a minimum of one abstinence based self-help group and one caduceus/peer group per week for at least the first year.

Like all PHPs, we recommend UPHP require each participant to obtain a supervising physician or workplace monitor. Typically the participant must meet with this individual once per month and this individual should be educated in the identification of potential work-site impairment. While the participant may suggest their monitor, the decision ultimately must be made jointly between the participant, UPHP**,** and the employer. The supervising physician or workplace monitor must agree to submit a status report on a quarterly basis unless there are concerns, in which case such concerns should be immediately conveyed to the Case Manager assigned to the participant. There are several examples of Work Place Monitoring Forms included in the State PHP Information Packets. It should be noted there is an example of Oklahoma's PHP Work Place Monitoring Form within Montana's packet. This is because the individual who designed the form and provided it to us previously worked for Oklahoma's PHP and is now employed by Montana's PHP.

Frequency of Monitoring

Participants in PHPs are assigned a Case Manager who is responsible for monitoring and meeting with the participant. The Case Manager, as indicated above, should hold at minimum a master's degree in mental health and**,** while their role is not to provide treatment**,** they should have an expertise in treating substance use disorders. They answer questions from the

participants, coordinate with the participant, check in with their progress in recovery, and respond to compliance violations. Most contact occurs over the phone.

The frequency and type of in-person contact varies greatly across PHPs. For example, North Carolina's PHP employs master's level Field Coordinators who conduct random monthly in-person visits during the first three years. Some PHPs meet with participants only when issues of noncompliance occur. Some meet quarterly. Sometimes these protocols are by design, sometimes they are based on budgetary constraints, and sometimes they are based on geographical challenges.

Given the success rates of PHPs and the variation among PHPs in how often the Case Manager meets with the participant in-person, it appears that monitoring, frequent telephone contact, earned advocacy, and quick response to issues of compliance are likely more important than how often, or in what setting, in-person meetings takes place. That said, we spoke with programs who desire more contact with participants as a form of advocacy and encouragement. Unless there are issues of compliance, we recommend Case Managers schedule, at minimum, quarterly individual face-to-face visits with their participants and that they have frequent telephone contact. UPHP may also want to consider a policy in which the in-person visits are reduced over time with successful participation in the Program. Finally, UPHP should consider teleconferencing as an occasional option for individuals who are compliant and for whom travel may be difficult.

Length of Monitoring

The minimum length of monitoring for a participant diagnosed with a moderate or severe substance use disorder should be 5 years. Participants who have been diagnosed with a mild substance use disorder are typically monitored for 1 to 2 years depending upon the recommendations of the assessment. Most PHPs include wording in their Monitoring Contract that clearly states the length of monitoring can or will be extended in the event of a relapse or substantial noncompliance. We also recommend there be no barriers to reentry for individuals who wish to return to the Program at any time in the future as long as they meet eligibility requirements. Finally, we recommend that participants be able to choose to extend their monitoring indefinitely.

Fees

We discovered a wide variation of monthly fees among the 12 PHPs with whom we spoke. This ranged from no charge at all to $435 per month. All PHPs who charged monthly fees adjusted those fees depending upon the profession, whether the participant is currently practicing, and whether the participant is a student or resident. The participant always bears the cost of any treatment or toxicology screening.

The monthly cost of participation in a PHP, in almost all cases, is directly linked to funding, and thus we cannot recommend a monthly fee at this time. In both Iowa and Minnesota, where the PHP exists within the regulatory authority, there are no fees. If UPHP continues to exist within DOPL, we would recommend the same. Regardless, we recommend efforts to obtain funding from multiple sources such as hospitals, professional organizations, malpractice insurance companies, private contributions, licensing fees, licensing fines, and the legislature. This achieves buy-in from the stakeholders and helps decrease the likelihood that costs become a barrier to participation.

Toxicology Screening

All PHPs we spoke with employ specific policies and procedures outlining the frequency of screening**,** which typically decreases over the course of compliant participation. Most programs typically screen approximately once per week during the first year of participation, approximately twice per month during the second year, and then once per month or on a quarterly basis thereafter. It is recommended that UPHP adopt similar policies.

Screening, of course, should increase when issues of noncompliance or suspected noncompliance (such as a diluted specimen) occur or when the participant is at increased risk for a relapse. We also recommend, consistent with North Carolina's PHP policy, that individuals who miss a screening be required to submit a sample the following day. Furthermore, the Monitoring Agreement should clearly state that any specimen flagged as dilute or abnormal will be retested and that the participant will bear the cost.

Screenings may include urine, hair, nail, blood, or saliva. The choice of which bodily fluids or substances are to be screened should be based, to a large extent, on the primary drug of abuse. UPHP's Medical Director should assist in developing policies and procedures for these protocols. Finally, many PHPs are using remote alcohol monitoring alternatives such as Soberlink. Typically this does not replace urinalyses screenings but reduces the number required.

Responding to Substance-Related Relapses

As indicated in the Evaluation Report, UPHP should consistently use a graduated protocol for responding to relapses and the Case Manager should immediately reach out to the participant who has relapsed. The Federation of State Medical Boards (FSMB) has established three levels of relapse behaviors that serve as excellent guidelines. They are as follows:

Level 1 Relapse: Behavior without chemical use that might suggest impending relapse
Level 2 Relapse: Relapse with chemical use that is not in the context of active medical practice
Level 3 Relapse: Relapse with chemical use in the context of active medical practice

A Level 3 Relapse should always result in a request to the participant to withdraw from practice, obtain an evaluation, and adhere to new treatment recommendations. A determination of when the participant is able to return to work is then made by the treatment facility with advocacy from the PHP. Should the participant refuse to withdraw from practice, the PHP should immediately report him or her to the respective Board, which typically results in probation or other action. As mentioned above, if an individual is on probation then safe harbor no longer applies and disciplinary information can be accessed by the public. However, the Board may still choose to have all monitoring take place within the PHP.

While any relapse should be carefully reviewed and discussed with the entire UPHP team, a review of a Level 2 Relapse should include the circumstance of the relapse, the severity of the relapse, the legality of the substance**,** and whether the substance is one in which there is a history of a diagnosed substance use disorder.

Because a Level 1 relapse does not involve a chemical substance, it will be elaborated upon below.

Like most PHPs, we recommend all Level 2 and 3 Relapses be reported to the respective Board. However, there may be circumstances previously agreed upon by UPHP and the Board in which immediate reporting is unnecessary in the case of a Level 2 Relapse. As indicated in the Evaluation Report, a trusting and transparent professional relationship with the Board is imperative. We further recommend, consistent with many PHPs, that UPHP attend each Physician, Nurse**,** and Pharmacy Board meeting and provide a report to the Board that includes information regarding those participants who are not compliant. Discussion of options should be a collaborative and educational process; however, it should also be recognized that the clinical expertise exists within the PHP. Some PHPs do not provide any identifying information when discussing a participant's noncompliance with the Board. Some are legislatively mandated to provide the participant's name. It is recommended that UPHP work with each Board to determine the desired protocol.

Responding to Other Noncompliance

Typically, a missed screening will be viewed as a Level 1 Relapse as described above. Often PHPs respond by increasing testing or other treatment/aftercare requirements, and we would recommend doing the same on a case-by-case basis.

PHPs often struggle to determine the optimal way to respond to the occasional missed submission of paperwork or missed attendance at a group, particularly when the participant is compliant with all screenings and is demonstrating abstinence. Still, if left unaddressed, these behaviors can become a pattern and may be a precursor to a relapse. Mississippi responds to these issues by increasing the number of screenings, which serves as both a means to determine if these behaviors are suggestive of relapse as well as a financial consequence. Both Montana and Iowa use a graduated approach that we recommend implementing. First, the

participant is contacted by the Case Manager and the noncompliance is discussed. If it occurs again, the participant receives a letter indicating his or her compliance is in jeopardy. Should it happen a third time the matter is reported to the Board.

Moving Forward

Clearly, our suggestions, if implemented, result in a PHP that looks very different from the existing Program. We recognize that change can be difficult even in the best circumstances. However, we also strongly believe that, should our recommendations be followed, Utah will emerge with an exceptional PHP. In order to successfully navigate these changes, we recommend soliciting input from the Boards and Professional Organizations as well as other stakeholders. Because the existing statute cannot be adapted in rule to meet the new structure we are proposing, DOPL will need to explore avenues for statutory amendments. URAP will also need legal guidance to become well-versed in the laws governing the confidentiality of their participant information. It is important to remember that these regulations are governed under Title 42 of the Code of Federal Regulations (42 CFR) and not the Health Insurance Portability and Accountability Act (HIPAA). Once the structure and details have been approved, policies and procedures should be developed, most of which can be adapted from the forms included in our Report. Because we are not recommending a Committee format and because we are limiting the professions served by the program, there will need to be a compassionate and well-thought-out plan to phase out the current program.

As indicated above, the 12 PHP Executive Directors we spoke with were generous in their time and information, and FSPHP is an invaluable resource for information and problem solving. As the finer details of the program emerge, we would encourage you to reach out to them as needed. Finally, we are happy to provide guidance as the Program moves forward.

ATTACHMENTS

ATTACHMENT A

DOPL INVESTIGATIONS UNIT SUBSTANCE USE CASES

2017 Investigations Unit; Substance Use Cases

Profession	Closure Code	Count
Burglar Alarm		
	Administrative Action	2
	Administrative Discretion	3
	Court Report	1
	Lack of Evidence	1
	Pharmacy Alert	1
Clinical Mental Health		
	Verbal Warning	1
Cosmetology		
	Administrative Action	3
	Administrative Discretion	5
	Court Report	1
	Lack of Evidence	1
	Letter of Concern	4
	Unfounded	3
	Verbal Warning	1
Dental		
	Administrative Discretion	1
	Lack of Evidence	1
	Letter of Concern	1
	Referred to URAP	2
	Voluntary Compliance	1
Electrician		
	Letter of Concern	1
Engineer/Land Surveyor		
	Letter of Concern	1
Massage		
	Administrative Action	1
	License Expired	1
Nurse		
	Adminsitrative Action	7
	Adminstrative Discretion	4
	Citation Issued	1
	Death of Respondent	1
	Lack of Evidence	2
	Letter of Concern	7
	Medical Examiner	1
	No Jurisdiction	1
	Referred to URAP	4
	Referred to Other Agency	2
	Unfounded	5
	Verbal Warning	1
Pharmacy		
	Administrative Discretion	1
	No Jurisdiction	2
Physician		
	Administrative Action	1
	Consolidated to Another Case	2

2018 Investigations Unit; Substance Use Cases

Profession	Closure Code	Count
Chiropractic		
	Unfounded	1
Clinical Mental Health	Administrative Action	2
Contractor		
	Administrative Action	2
	Citation Issued	1
Cosmetology		
	Administrative Action	1
	Administrative Discretion	2
	Letter of Concern	1
	Unfounded	1
Dental		
	Letter of Concern	1
	Unfounded	2
Electrician		
	Letter of Concern	1
Nurse	Adminstrative Action	10
	Administrative Discretion	3
	Citation Issued	5
	Consolidated to Another Case	2
	Letter of Concern	12
	Referred to URAP	4
	Unfounded	1
Pharmacy		
	Administrative Action	3
	Administrative Discretion	1
	Letter of Concern	7
	Referred to URAP	1
	Unfounded	1
Physical Therapist		
	Administrative Discretion	1
Physician		
	Administrative Action	2
	Referred to URAP	2
	Unfounded	1
Psychologist		
	Referred to URAP	1
Radiology		
	Referred to URAP	2
Respiratory Care		
	Unfounded	1
Security Guard		
	Referred to URAP	1

2017 Investigations Unit; Substance Use Cases Continued		
Profession	**Closure Code**	**Count**
	No Jurisdiction	1
	Referred to URAP	1
	Unfounded	1
	Verbal Warning	1
	Voluntary Compliance	1
Radioloy		
	Administrative Action	1
	Lack of Evidence	1
Security Guards		
	Administrative Action	1
	Administrative Discretion	1
	Pharmacy Fax	2
Social Work		
	Lack of Evidence	1
	Letter of Concern	3
	Referred to Other Agency	1
Substance Use Disorder		
	Referred to URAP	1
Veterinarian		
	Unfounded	1
2017 Total to URAP		8

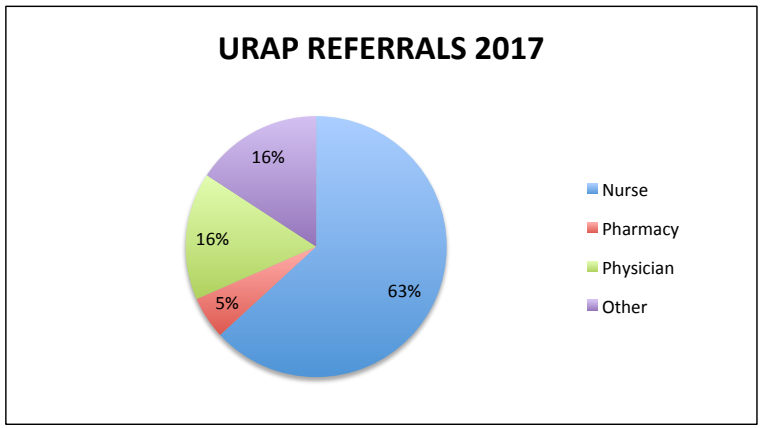
2018 Investigations Unit; Substance Use Cases Continued		
Profession	**Closure Code**	**Count**
Social Work		
	Administrative Discretion	2
Substance Use Disorder		
	Administrative Action	1
Veterinarian		
	Administrative Action	1
2018 Total to URAP		11

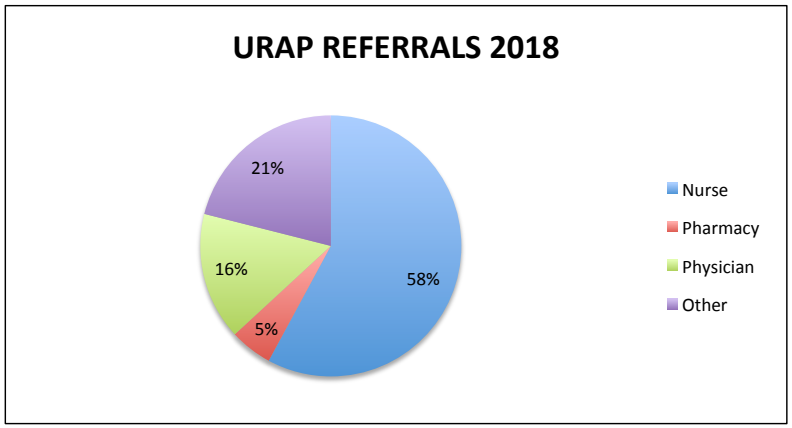
2017 Investigations Unit; Diversion Cases		
Profession	**Closure Code**	**Count**
Burglar Alarm		
	License Expired	
Cosmetology		
	Administrative Action	
Nurse		
	Adminstrative Action	
	Administrative Discretion	
	Criminal Action	
	Lack of Evidence	
	Letter of Concern	
	No Juridiction	
	Referred to URAP	
	Referred to Other Agency	
Osteopathic Physician		
	Administrative Action	
Pharmacy		
	Administrative Action	
	Death of Respondent	
	Letter of Concern	
	Referred to URAP	
Physician		
	Administrative Action	
	Referred to URAP	
	Unfounded	
Physician Assistant		
	Administrative Discretion	
2017 Total to URAP		11

2018 Investigations Unit; Diversion Cases		
Profession	**Closure Code**	**Count**
Health Facility		
	Administrative Discretion	1
Nurse		
	Adminstrative Action	13
	Adminstrative Discretion	1
	Citation Issued	2
	Consolidated to Another Case	2
	Letter of Concern	5
	No Jurisdiction	5
	Referred to URAP	7
	Unfounded	4
Pharmacy		
	Administrative Action	4
	Administrative Discretion	2
	Lack of Evidence	1
	Letter of Concern	1
Physician		
	Criminal Action	1
	Referred to URAP	1
	Unfounded	1
Physician Assistant		
	Lack of Evidence	1
2018 Total to URAP		8

2017 Investigations Unit; Diversion & Substance Use Cases	Disposition	Count
Nurse	Other	62
	Referred to URAP	12
Osteopathic Physician	Other	1
	Referred to URAP	0
Pharmacy	Other	12
	Referred to URAP	1
Physician	Other	9
	Referred to URAP	3
	Total	100
	Total to URAP	16
		16%
Total to URAP 2017 (All Professions)	19	
Unlisted Referred	SUD License (1)	
	Dental License (2)	

2018 Investigations Unit; Diversion & Substance Use Cases	Disposition	Count
Nurse	Other	60
	Referred to URAP	11
Pharmacy	Other	20
	Referred to URAP	1
Physician	Other	5
	Referred to URAP	3
	Total	100
	Total to URAP	15
		15%
Total to URAP 2018 (All Professions)	19	
Unlisted Referred	Psychologist (1)	
	Radiology (2)	
	Security Guard (1)	





ATTACHMENT B

MONTANA CODE RELATED TO THEIR PHP

37-3-203. Powers and duties. (1) The board may:

(a) adopt rules necessary or proper to carry out the requirements in Title 37, chapter 3, parts 1 through 4, as well as chapters covering podiatry, acupuncture, physician assistants, nutritionists, and emergency care providers as set forth in Title 37, chapters 6, 13, 20, and 25, and **50-6-203**, respectively. The rules must be fair, impartial, and nondiscriminatory.

(b) hold hearings and take evidence in matters relating to the exercise and performance of the powers and duties vested in the board;

(c) aid the county attorneys of this state in the enforcement of parts 1 through 4 and 8 of this chapter as well as Title 37, chapters 6, 13, 20, and 25, and Title 50, chapter 6, regarding emergency care providers licensed by the board. The board also may assist the county attorneys of this state in the prosecution of persons, firms, associations, or corporations charged with violations of the provisions listed in this subsection (1)(c).

(d) review certifications of disability and determinations of eligibility for a permit to hunt from a vehicle as provided in **87-2-803**(11); and

(e) fund additional staff, hired by the department, to administer the provisions of this chapter, by increasing license fees as necessary.

(2) (a) The board shall establish a medical assistance program to assist and rehabilitate licensees who are subject to the jurisdiction of the board and who are found to be physically or mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug or substance or by mental illness or chronic physical illness.

(b) The board shall ensure that a licensee who is required or volunteers to participate in the medical assistance program as a condition of continued licensure or reinstatement of licensure must be allowed to enroll in a qualified medical assistance program within this state and may not require a licensee to enroll in a qualified treatment program outside the state unless the board finds that there is no qualified treatment program in this state.

37-2-202. Confidentiality of medical assistance program information -- health care information. (1) The proceedings and records of a medical assistance program created in chapter 3, 4, 7, or 8 relating to a licensee who has received or is receiving assistance from the medical assistance program:

(a) are confidential and are considered to be proceedings and records of a professional standards review committee under **37-2-201**; and

(b) are not subject to discovery or introduction into evidence in any administrative or judicial proceeding other than a disciplinary proceeding against the licensee before the applicable licensing board. If the proceedings and records are introduced into evidence in a disciplinary proceeding, the introduced materials are public unless otherwise protected by law.

(2) Any health care information, as defined in **50-16-803**, that is maintained by a health care provider in the provision of health care services to a licensee participating in a medical assistance program provided for in chapter 3, 4, 7, or 8 is subject to discovery from the licensee or the health care provider and to introduction into evidence in an administrative or judicial proceeding as may otherwise be allowed by law.

ATTACHMENT C

ADDICTION TREATMENT & ASSESSMENT PROGRAMS

Caron (Pennsylvania)
- https://www.caron.org/our-programs/inpatient-treatment/healthcare-professionals

Hazeldon Betty Ford (various states)
- https://www.hazeldenbettyford.org/treatment/models/specialized-programs/health-care-professionals

Behavioral Health of the Palm Beaches (Florida)
- https://www.bhpalmbeach.com/programs/professional-programs/healthcare-professionals-treatment/

The Oaks at La Paloma (Tennessee)
- https://theoakstreatment.com/drug-rehab/for-health-care-professionals/

Bradford Health Services (Alabama)
- https://bradfordhealth.com/specialty-programs/healthcare-professionals-program/

Positive Sobriety Institute (Illinois)
- https://www.positivesobrietyinstitute.com/substance-abuse-treatment/mcap/

My Doctor Medical Group (California)
- https://mydoctorsf.com/professional-substance-abuse-evaluations/

Pavillon (North Carolina)
- www.pavillon.org

Positive Sobriety Institute (Chicago)
- www.positivesobrietyinstitute.com

Promises Treatment Centers (California)
- www.promises.com

Talbott (Georgia)
- www.talbottcampus.com

University of Florida Recovery Center (Florida)
- http://floridarecoverycenter.ufhealth.org/category/scott-teitelbaum-md/

Acumen Assessments (Kansas)
- www.acumenassessments.com

Professional Renewal Center (Kansas)
- www.prckansas.org

Vanderbilt University Medical Center Comprehensive Assessment Program
- http://www.mc.vanderbilt.edu/root/vumc.php?site=vcap

TABLES

PROCESS FOR INITIATING PARTICIPATION

State	Most Frequent Way of Initiating the Process	Intervention Offered		Exclusion Criteria				Assessment	
		Yes	No	None	Some Sexual Misconduct	Some Legal Issues	Case by Case	Done Within PHP	Provided Three Referrals
Colorado	Phone		X	X				X	
Georgia	Phone		X		X				X
Indiana	Phone		X	X					X
Massachusetts	Phone		X	X				X	
Mississippi	Phone		X	X					X
Montana	Phone	X			X	X			X
North Carolina	Phone		X	X					X
Tennessee	Phone		X		X				X
West Virginia	Phone	X					X		X
Iowa	Phone		X	X					X
Minnesota	Phone		X	X					X
Idaho	Phone	X		X					X

MONITORING & TESTING

State	Length of Monitoring					Testing Facility	Frequency of Testing per Month	
	6 months - 1 Year for Mild SUD	1 - 2 Years for Mild SUD	3 Years for Mild To Moderate SUD	5 Years for Moderate to Severe SUD	Case by Case		Early Participation	Progressive Compliant Participation
Colorado				X	X	RecoveryTrek	8	Unspecified Frequency
Georgia		X		X		Spectrum	2	Unspecified Frequency
Indiana	X			X		Spectrum	2	1
Massachusetts				X	X	RecoveryTrek	8-12	2
Mississippi		X		X		Spectrum	3-4	1
Montana		X		X		RecoveryTrek	3-4	2
North Carolina		X		X		RecoveryTrek	3-4	1
Tennessee					X	Spectrum	4	2
West Virginia		X		X		FSSolutions	4	2
Iowa			X	X		RecoveryTrek	4	Unspecified Frequency
Minnesota		X	X	X		local certified lab	3	2
Idaho				X	X	FSSolutions	1	Unspecified Frequency

FUNDING & FEES

State	Funding Sources									Monthly Fees	
	Private Contributions	Professional Boards	Hospital Contributions	Participant Fees	Medical Association	Professional Organizations	Licensing Renewal Fees	Malpractice Insurance Companies	Other	Free	Scaled Depending on Profession
Colorado	X	X							X	X	
Georgia			X	X							$100-$435
Indiana	X			X	X						$20-$200
Massachusetts		X				X		X		X	
Mississippi	X			X			X				$50-$200
Montana				X					X		$110-$172
North Carolina	X	X	X	X		X	X				$5-$250
Tennessee			X	X				X	X	X*	
West Virginia			X	X			X				$50-$200
Iowa									X	X	
Minnesota		X							X	X	
Idaho					X				X		Did Not Disclose Amount
										*$140 if non-mandated	

CAN PARTICIPANTS BE PRESCRIBED CONTROLLED SUBSTANCES

State	Benzodiazepine		Stimulants		Medically Necessary Opioids				Buprenorphine				Medical Marijuana			Recreational Marijuana		
	Yes	No	Yes	No	Yes	No	Allowed to Practice	Not Allowed to Practice	Yes	No	Taper Required	Taper Not Required	Yes	No	N/A	Yes	No	N/A
Colorado	X*		X		X		X		X			X		X		X*		
Georgia		X	X		X		X		X			X			X			X
Indiana		X	X		X			X	X*			X			X			X
Massachusetts		X	X		X		X		X			X		X			X	
Mississippi		X	X			X				X					X			X
Montana		X	X		X		X		X			X		X				X
North Carolina		X	X		X			X	X		X				X			X
Tennessee		X	X		X			X	X			X			X			X
West Virginia		X	X		X			X	X			X		X				X
Iowa		X	X		X		X		X			X		X				X
Minnesota	X*		X		X		X		X			X		X				X
Idaho		X	X		X			X	X		X				X			X
	*The participant must be evaluated by an expert in addiction		In all cases, the participant must be evaluated by an expert in addiction						*Must be approved by two addictionologists							*Case by case basis		

RESPONSE TO NONCOMPLIANCE

State	Response to Chemical Relapses			Formal Tiered Response to Non Compliance (not substance related)		Safe Harbor for Non-Mandated Compliant Participants		Safe Harbor for Mandated Compliant Participants	
	Case by Case	Level System	Asked to Stop Practicing & Reassessed	Yes	No	Yes	No	Yes	No
Colorado	X			X		X			X
Georgia	X			X		X		X	
Indiana		X			X	X			X
Massachusetts	X				X	X		X	
Mississippi	X		X		X	X			X
Montana	X		X	X		X*		X	
North Carolina	X		X		X	X			X
Tennessee		X		X		X			X
West Virginia		X		X		X			X
Iowa	X		X	X		X		X	
Minnesota	X		X	X		X		X	
Idaho	X				X	X			X
						*Due to statute, all professions but nurses are able to remain anonymous to the Board			

ACTIVE PARTICIPANTS

State	# of Participants	Percentage of Non-Mandated Participants	Can Participants Return?
Colorado	500	15%-20% SUD; 80% total are non-mandated	Yes
Georgia	250	85% non-mandated	Yes
Indiana	180	90%-95% non-mandated	Yes
Massachusetts	140	75% non-mandated	Yes
Mississippi	120	90% non-mandated	Yes
Montana	120	60%-65% non-mandated	Yes
North Carolina	286	40% non-mandated	Yes
Tennessee	220	43% non-mandated	Yes
West Virginia	80	95% non-mandated	Yes
Iowa	42	81% non-mandated	Yes
Minnesota	600	50% non-mandated	Yes
Idaho	Did not disclose	35% non-mandated	Yes

STATE PHP INFORMATION PACKETS

Colorado Physician Health Program

SINCE 1986

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

Case by case

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Assessment done within PHP

TESTING

Agency: RecoveryTrek
Frequency: Twice per week, decreasing as participants progress

REQUIRED MEETINGS

Varies in frequency based on assessment. Typically includes weekly 12 Step meetings and caduceus meetings

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Once a week, then decreases once stable.
In-person at first.
Psychiatrists travel to rural areas once per quarter to meet with participant

CHEMICAL RELAPSES

Case by case, no level system used

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Tiered response

CONTROLLED SUBSTANCES

Benzodiazepine: Case by case (with evaluation)
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary (may be able to practice)
Buprenorphine: Yes (taper not required)
Medical Marijuana: No
Recreational Marijuana: Case by case basis

PROFESSIONS SERVED

Physicians – MD/DO
Families of physicians
Medical students
Residents
Physician assistants
Physician Assistant students
Anesthesiology assistants

LENGTH OF MONITORING

Case by case (related to state regulations)
5 years for severe SUD

APPROXIMATE FEES

Free

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Submission of quarterly reports with identifying information; if relapse occurs, Board is notified within 24 hours

STAFF

Sarah R. Early, PsyD,
Executive Director

6 part time Medical Directors
1 LCSW
1 Director of Public Affairs

FUNDING SOURCES

Private contributions
Professional boards
Generates 10% from presentation fees, honorariums, and training program contracts

OF ACTIVE PARTICIPANTS

500 (15%-20% SUD)
80% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

95% completion rate

Table of Contents

Colorado
Physician Health Program

Colorado Physician Health Program (CPHP)
Credentialing and Status Reports for Active CPHP Participants
Policy and Procedures

POLICY:

A credentialing status report requested by an individual or entity, organization or institution is provided by CPHP for a fee of $35.00 per report. Exclusions to policy: There is no fee associated with reports requested by state Physician Health Programs, initial evaluation reports furnished to the referral source (workplace, etc.) or initial evaluation credentialing status reports. Please note: CPHP does not provide reports on participants whose case has been inactivated for one year or longer.

PROCEDURES:

Step 1:
If the requesting entity has reason to believe that the individual for whom they are requesting a report from CPHP is/was involved with CPHP, the entity must initially contact the individual for whom they are requesting a report on, and direct that person to call CPHP and arrange for a proper CPHP release of information form to be signed. CPHP does not honor external release/consent forms that are generated outside of CPHP. If the entity does not take this step, and instead contacts CPHP to begin the process, CPHP will neither confirm nor deny that the individual is known to CPHP and will direct the entity to follow the procedures as outlined above in this policy.

If the requesting party is the individual himself/herself, the individual needs to contact CPHP and arrange to complete the proper CPHP release of information form. CPHP will not respond to any report request without a written release of information in place, no exceptions. This policy is in adherence to CPHP's policies on confidentiality. Release of information forms that are currently on file at CPHP are valid for active participants.

Step 2:
Once a CPHP release of information form is completed, the individual will be directed by CPHP to contact the requesting entity and inform them that he/she has completed the CPHP release of information form.

Step 3:
Once the requesting entity has received confirmation from the individual that the CPHP release of information form is in place, the requesting entity must mail a completed CPHP Credentialing Status Report Request Form along with payment of $35. Payment must be received in order for the request to be processed.

Step 4:
Upon receipt of the completed CPHP Credentialing and Status Report Request Form, payment and confirmation that a valid release of information form is in place, CPHP will prepare a report within thirty days from the date the request is received. There are no exceptions to this policy. If the requested report will not be provided as outlined in this policy, CPHP will contact the requesting entity immediately.

Approved: on file Date: 4/1/03
Policies and Procedures 2003

Colorado
Physician Health Program

CONFIDENTIALITY AGREEMENT

Client #_____

The following agreement is entered into this _____ day of _____, 20_____, between the Colorado Physician Health Program (CPHP) and _____ (participant). The term participant is used as no physician/patient relationship is created. CPHP does not provide treatment.

The purpose of this agreement is to document the confidentiality provided to the participant and the limits of this confidentiality to assure protection of public health, safety and welfare.

Confidentiality: You will be assigned a code number to assure your anonymity within the program.

Colorado law and federal law govern confidentiality of your name and information about your participation in certain instances.

If your participation at CPHP involves an alcohol or drug problem, federal law provides only three conditions under which CPHP can release any information about your participation: 1) you consent in writing; 2) if the disclosure is allowed by a court order; 3) if the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a participant, either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. Sections 290dd-3 and 290ee-3 for federal laws and 42 C.F.R. Part 2 for federal regulations.)

Consent: In order to administer the program effectively, CPHP needs your consent (as evidenced by your signature below) for disclosure under certain circumstances; CPHP shall not have a duty to report unless you meet one of the situations listed below:

1) A determination by CPHP clinical staff that you may present a danger to yourself or others; Or that you may present a significant risk in your medical practice;

2) A determination by CPHP clinical staff that you have failed to comply with the terms of your treatment/monitoring program and that in the opinion of CPHP clinical staff you may present a danger to yourself, others or your medical practice;

3) A determination by CPHP clinical staff that an obligation to report exists based on violation of one or more provisions of the Colorado Medical Practice Act (CRS 12-36-117 Unprofessional conduct.) in which harm to a patient may have occurred.

4) Pursuant to a subpoena issued by the CMB, in connection with a written complaint alleging unprofessional conduct, as provided in Section 12-36-118, C.R.S.; or in connection with an investigation related to a licensure application, as provided in Section 12-36-111, C.R.S.

Execution of this agreement constitutes your consent to disclose your identity and the entire contents of your file to the Colorado Medical Board (CMB) if you meet one of the above conditions; this may include redisclosure of reports made by outside providers or programs even if your involvement with CPHP was or is on a voluntary basis.

Your file, which may be reviewed by you, may contain information related to an evaluation ordered by the CMB or an employer, as well as self-referral information. You may revoke your consent of disclosure at any time, except to the extent that CPHP has already taken action in reliance on previous consent as expressed in this agreement. Such revocation must be presented to CPHP in writing. Revocation of consent shall not prevent disclosures by CPHP to the CMB, law enforcement authorities or third persons, if otherwise required by law. If not previously revoked, your consent will terminate automatically 90 days after your discharge from the Colorado Physician Health Program. Your discharge date is the date CPHP inactivates your case.

I acknowledge my participation in the Colorado Physician Health Program, which involves specific provisions for confidentiality, consent and revocation of consent. I further understand the Colorado Physician Health Program's reporting obligations, which are limited to the circumstances described above.

Date_____ Signature:_____
(Month/Day/Year)

Printed Name:_____

Template Referral Letter

Date

Dear Referred Individual's NAME,

You have been referred to CPHP on [DATE] for [ISSUE].

We will expect you to sign releases at CPHP so that the Clinician and evaluating psychiatrist can obtain information from and provide information to the following individuals.

(Note to Referral Party: List any individuals you would like for CPHP to speak with concerning this employee: Suggestions listed)

HUMAN RESOURCES
CREDENTIALING
MEDICAL EXECUTIVE COMMITTEE
CHIEF OF STAFF
SUPERVISING PHYSICIAN'S NAME
OTHER NAME/S

We expect that you will contact CPHP no later than [DATE] to make an appointment. Once you make an appointment at CPHP, please immediately notify your supervisor, [SUPERVISOR'S NAME] of the date of your appointment. You will receive an appointment letter from CPHP that will document when your appointment has been scheduled; this can be used as appointment confirmation. CPHP will not be able to confirm an appointment directly to us until a Release of Information is signed on the date of your appointment.

CPHP will communicate with [REFERRED INDIVIDUAL] once the evaluation has begun and may request or provide other information regarding your status and assessment.

If you would like more information regarding CPHP see their web site at www.cphp.org.

Sincerely,

REFERRING PARTY

cc: CPHP

Colorado
Physician Health Program

UDS EXCUSE REQUEST

Attention Compliance Coordinator at CPHP:

Today's Date: _____

Colorado Physician Health Program
899 Logan St. # 410 Denver, CO 80203
Phone: (303) 860-0122
Fax: (303) 860-7426

***CPHP requires at least two weeks' notice on any UDS excused request. Last minute requests will not be considered without documentation of the emergency.**

From/Name: _____

I am requesting to be excused from urine drug screen monitoring on the following date(s):_____

_____

_____

_____

_____

I will be:_____

_____

_____

_____

_____

_____ Please Provide Destination Zip Code: _____

I can be reached at the following number(s) and a confidential message can be left regarding this request:

_____

For CPHP use only

- ☐ excused
- ☐ excused with make up on _____
- ☐ not excused
- ☐ client contacted
- ☐ Compliance Coordinator to contact client
- ☐ Initials: _____

***Spirit of Medicine* Campaign**
Donation/Pledge Form
(Please print clearly)

Yes, I want to support Colorado Physician Health Program's mission of assisting Colorado physicians, residents, medical students, physician assistants and physician assistant students who may have health problems, which if left untreated, could adversely affect their ability to practice medicine safely.

Prefix:
(i.e., Dr., Ms., Mrs., Mr., Rev., Rabbi, Hon., etc.)

Suffix:
(i.e., M.D., D.O., PhD., Esq., etc.)

First Name:

Middle Initial:

Last Name:

Organization:

Address:

City:

State:

Zip:

Home Phone:

Work Phone:

Email:

Yes! I want to support Colorado Physician Health Program, please accept my tax-deductible gift of:
○ $50 ○$100 ○$250 ○$500 ○Other_____

LivingWell Giving Society:

- ○ $2500 per year for 5 years
  This represents the cost of comprehensive diagnostic evaluation for Physician, Physician-in-Training, or Physician Assistant.
- ○ $10,000 per year for 5 years
  This represents the cost of an annual Physician Health Community Symposium.
- ○ $25,000 per year for 5 years
  This represents the cost of the Physician Health Workplace Training Series.
- ○ $50,000 per year for 5 years
  This represents the cost of an additional clinical staff person to expand CPHP services in areas such as improved outreach and education across Colorado.

○ ***Eternal Life*** Legacy Program:

○ will/bequest ○ life insurance ○ trust ○ stock
○ annuity ○ property

Tribute gift:
Please make my gift in:
honor of:_____ memory of:_____

Send acknowledgement card to:
Name:_____
Street:_____
City:_____State:_____Zip_____-_____

Sign card from:_____

Gift Matching:
My workplace will match my contribution: ○Yes ○No
Name of workplace:_____
Address:_____

Gift Recognition:
○I/We prefer to be recognized by: (choose one)
○Name:_____
○Practice/Organization:_____

○Please do **not** publish my name or practice as a donor (check only if you do not want to recognition of any kind)

○Please make checks payable to **Colorado Physician Health Program**.

Keep a copy of this form and mail original to:
Spirit of Medicine Campaign
Colorado Physician Health Program
899 Logan Street, Suite 410
Denver, CO 80203-3156

Thank you for your generous support and commitment to CPHP's mission!

Colorado
Physician Health Program

PRESENTATION REQUEST

Date of Request_____

Name of Organization_____

Mailing Address _____

City, State, Zip_____

Name & Title of Contact Person_____

Phone Number_____ Fax Number_____

E-Mail Address_____

Requested Date & Time for Presentation_____

2nd Choice_____

Topic for Presentation_____

Audience (e.g. medical staff, residents, specialty, MEC's)_____

Number of attendees expected _____

Location of Presentation (e.g. address, room number, directions)_____

_____

_____

Honorarium offered (please specify amount) _____

LCD capability? Yes___ No___ Laptop? Yes___ No___

CPHP will provide learning objectives, brochures and other handouts.

_____

Please complete this form and return via mail or fax to:
Colorado Physician Health Program
Attention: Presentation Request
899 Logan St. Suite 410
Denver, CO 80203

Phone: 303-860-0122, Fax: 303-860-7426

Colorado
Physician Health Program

Colorado Physician Health Program (CPHP)
Credentialing and Status Report Request Form

Client Name: _____ Date of Birth: _____

Requesting Entity
Institution/Organization Name:

_____

Addressee/Title:

_____

Address:

_____
_____
_____

Phone Number:

_____

Please mail report request along with a $35 processing fee in the form of a check to:

Colorado Physician Health Program
Attn: Report Request Department
899 Logan Street, Suite 410
Denver, Colorado 80203-3156

There is no fee for initial reports*

We regret that CPHP is unable to process credit cards at this time.

In accordance with CPHP Policy and Procedures for Credentialing Reports for Active CPHP Participants, CPHP can only honor report requests with proper release of information. CPHP operates on a thirty-day turn around time for Credentialing and Status Report Requests. If you have any questions, please contact us at **(303) 860-0122 ext. 0**.

Please copy this form as needed.

Internal Use Only:
Client Number: _____
Request received: _____
Check deposited: _____
Release on file: _____

Georgia PHP
Healthy Professionals, Healthy Georgia

SINCE 2012

INITIATING THE PROCESS

Phone call or email; email is not as common

EXCLUSION CRITERIA

Sexual misconduct

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: Spectrum
Frequency: Average twice per month; more frequent at start, then decreases

REQUIRED MEETINGS

Caduceus Meetings
Typically one other abstinent based meeting per week

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Initial intake meetings are done in person at the Atlanta office, as are meetings with struggling participants; otherwise, most everything else is done via phone

CHEMICAL RELAPSES

Case by case, graduated response, not necessarily a level system

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Tiered response

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary
Buprenorphine: Yes (taper not required)
Medical Marijuana: CBD only, no requirements for use
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D.
Physicians – D.O.
Medical students
Residents
Physician assistants
Respiratory Therapists

LENGTH OF MONITORING

Case by case: Mild SUD is typically 1 to 2 years, moderate to severe SUD is 5 years

APPROXIMATE FEES

$100-$435 depending on profession

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Yes, if compliant

STAFF

Paul H. Earley, MD, FASAM, Medical Director

1 Executive Director
1 Case Manager
1 Program Operations Manager

FUNDING SOURCES

Hospital contributions (minimal)
Participant fees (90%)

OF ACTIVE PARTICIPANTS

250
85% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

1.6%-2.65% per year relapse rate, 4-5 individuals turned over to the Board per year

Table of Contents

Paul H. Earley, M.D. FASAM
Medical Director
Robin F. McCown
Executive Director
675 Seminole Avenue, Suite 108
Atlanta, Georgia 30307
678-825-3764 Fax 855-781-4082

Georgia Professional Health Program (Georgia PHP, Inc.)
Substance Use Monitoring Agreement

Name: _____Home:_____

Home Address: _____Work:_____

City/State/Zip Code_____ Cell:_____

Current Sobriety Date: _____

Agreement Start Date: _____ Agreement End Date: _____

This agreement specifies the terms under which the Georgia PHP, Inc. will act in a monitoring and advocacy role to the Georgia Composite Medical Board (GCMB) and equivalent state licensing boards, hospitals, medical societies, the Drug Enforcement Agency and others. This agreement is not complete until I read and initial all items, sign at the end, and Georgia PHP, Inc. signs as well. When all of the above occur, I become a monitoring participant in the Georgia PHP, Inc.

_____I understand by my initials and signature on this document, that Georgia PHP, Inc. is contracted with Georgia Composite Medical Board (GCMB) to provide services of a professional health program. My participation with Georgia PHP, Inc. is voluntary. I am free to choose not to comply with the recommendations of Georgia PHP, Inc. and discontinue my participation at any time and work directly with the Georgia Composite Medical Board (GCMB).

Note: For Public Safety, the Georgia PHP, Inc. is required by Georgia Composite Medical Board (GCMB) to disclose the name of any health care practitioner that discontinues participation with the Georgia PHP, Inc. as a result of not complying with indicated recommendations and to consent to that disclosure as a prerequisite of participation in the Georgia PHP, Inc.

Per my medical provider, my working diagnoses at the start of this agreement are:

_____

_____

1. I understand that Georgia PHP, Inc. is not a treatment provider.

2. I understand this agreement may be lengthened or shortened at the discretion of the Medical Director and Georgia PHP, Inc. team.

    a. The Monitoring Agreement will be extended in the event of a relapse.
    b. The Monitoring Agreement may be extended for substantial noncompliance.
    c. The Monitoring Agreement may be extended if my recovery is unstable or has proved unstable in the past.

3. If indicated, I agree to any ongoing recommended evaluation, treatment and subsequent monitoring as directed by my treating provider or Georgia PHP, Inc. All costs related to this agreement are my responsibility.

4. I understand that Georgia PHP, Inc. recognizes substance use disorders affects the entire family. As such Georgia PHP, Inc. strongly encourages my family members seek their own care such as participation in a family program (if not already attended), self-help groups or private counseling.

5. I will immediately notify Georgia PHP, Inc. prior to any of the following: travel outside monitoring area, change of address or phone numbers, change of employment, any malpractice suits; arrests, psychiatric or medical hospitalizations, seeking or obtaining licensure in another state, change in mental status, or any other significant event.

6. I agree to attend the Georgia PHP, Inc. Participant Retreat held every 2 years.

7. I agree to return phone calls or messages from my Case Manager promptly. I understand that I am non-compliant if I refuse to meet (in person or via telephone) with my Case Manager.

8. If I choose to share a copy of this agreement, I will inform the person or entity that changes may have been made that are not reflected on this original document. Monitoring agreement changes are kept in the Georgia PHP, Inc. records. A letter summarizing participant monitoring requirements may be requested.

9. I agree to follow this ongoing monitoring agreement as outlined below.

A. **Support Group** ☐ Not Required at this time ☐ Requirement Met

_____I agree to submit my support group attendance via the Affinity system each month. I agree to have this completed the 10th day of the following month. This support group attendance requirement does not include my small group (if required) or my weekly Caduceus group meeting requirement.
The minimum weekly requirement is as follows:

- 90 meetings x 90 days if recommended in my continuing care plan from my treatment provider.
- Attend 4 self-help meetings per week in year one of monitoring agreement.
- Attend 3 self-help meetings per week in years two and three of monitoring agreement.
- Attend 2 self-help meetings per week in year four of monitoring agreement.
- Attend 1 self-help meeting per week after year four.

I agree to select and utilize a home support group _____ and sponsor _____ within 30 days. (I will notify my Case Manager via Affinity messaging).

B. **Caduceus Meetings** ☐ Not Required at this time ☐ Requirement Met

_____I agree to attend all scheduled **Caduceus Meetings** throughout the month. I agree to submit my caduceus attendance via the Affinity system each month. I agree to have this completed and submitted for review by the 10th day of the following month. There is some flexibility for isolated circumstances in which an absence might be necessary.

Release of information for Caduceus leader obtained ☐

Start Date: _____ Day of week/Time _____

Caduceus Group: _____

Address: _____

Facilitator**:** _____ Contact number**:** _____

C. Small Group ☐ Not Required at this time ☐ Requirement Met

_____I understand I am required to attend **Small Group** for 2 years and I must attend all scheduled Small Group Meetings throughout the month. There is some flexibility for isolated circumstances in which an absence might be necessary. I understand my small group leader submits a quarterly report about my progress to Georgia PHP, Inc.

Release of information for small group leader obtained ☐

Start Date: _____ Day of week/Time_____

Small Group: _____

Address: _____

Facilitator**:** _____ Contact number**:** _____

D. Attending Physician:

_____I agree to be seen a minimum of once per quarter. I understand it is my responsibility to clear any and all prescribed medications through my Georgia PHP Attending Physician. It is also my responsibility to document all the medication I am currently taking in the Affinity system.

_____I agree to submit my Attending Physician quarterly appointment attendance via the Affinity system. My Attending Physician is required to submit to Georgia PHP a brief report of my compliance quarterly.

Release of information for attending physician obtained ☐

Name: _____

Address: _____

City/State/Zip _____

Contact number: _____

Email address: _____

Reporting forms are located in Affinity under "Help Desk>Quickstart Guides". This must be faxed to 855-781-4082. Reports are due to Georgia PHP by the end of the Quarter (March 30, June 30, Sept 30 and Dec 31).

E. Primary Care Physician and Any Other Specialist:

_____I understand I must obtain a primary care physician. I agree to notify my primary care physician that I am in currently participating with Georgia PHP, Inc. and my working diagnoses.

Name: _____

Address: _____

City/State/Zip _____

Contact number: _____

Email address: _____

Release of information for Primary Care Physician obtained ☐

F. **Individual or Family Therapy:** ☐Not required at this time

_____I understand my individual or family therapist determines the frequency of visits. My Individual or Family Therapist is required to submit to Georgia PHP a brief report of my status quarterly.

Name: _____

Address: _____

_____

Contact number: _____

Email: _____

Release of information for Individual or Family Therapist obtained ☐

Reporting forms are located in Affinity under "Help Desk>Quickstart Guides". Forms must be emailed to the Compliance Officer peter.brennan@gaphp.org or faxed to 855-781-4082. Reports are due to Georgia PHP by the end of each Quarter (March 30, June 30, Sept 30 and Dec 31).

Supervising MD / Workplace Monitor:

_____I agree to find a Supervising MD / Workplace Monitor acceptable to the Georgia PHP within 45 days of the signing of this agreement. I agree to a supervisory meeting at a minimum of once per month. I understand it is my responsibility to make sure that these meetings occur.

_____I will provide my Supervising MD/ Workplace Monitor with the "Supervising MD / Workplace Monitor packet" that outlines the responsibility and requirements of this role. I acknowledge that it is my responsibility to ensure my Supervising MD / Workplace Monitor submits to Georgia PHP, Inc. a report of my status each quarter.

Reporting forms are located in Affinity under "Help Desk>Quickstart Guides". Forms must be emailed to the Compliance Officer peter.brennan@gaphp.org or faxed to 855-781-4082. Reports are due to Georgia PHP by the end of each Quarter (March 30, June 30, Sept 30 and Dec 31).

Name: _____

Address: _____

_____

Contact number: _____

Email: _____

Release of information for Supervising MD/Workplace Monitor obtained ☐

G. **Return to Work/Credentialing** Release of information for employer obtained ☐

Return to work on (date) :_____

Restrictions, if any:_____

_____

_____

Employer: _____

_____I understand obtaining letters for return to work are my responsibility

Complete a "Participant Letter request" form located in Affinity under "Help Desk>Quickstart Guides". Indicate if this individual/organization will need a quarterly report from Georgia PHP issued to them (March 30, June 30, Sept 30 and Dec 31st).

I am credentialed at the following hospital systems: I am **NOT** credentialed at any hospital or other system: ☐

I. System Name_____

Medical Staff Coordinator (include title): _____

Email: _____

Fax #: _____

Chief Medical Officer: _____

Email: _____

Fax #: _____

Release for system obtained ☐

II. System Name_____

Medical Staff Coordinator (include title): _____

Email: _____

Fax #: _____

Chief Medical Officer: _____

Email: _____

Fax #: _____

Release for system obtained ☐

System Name_____

Medical Staff Coordinator (include title): _____

Email: _____

Fax #: _____

Chief Medical Officer: _____

Email: _____

Fax #: _____

Release for system obtained ☐

Complete a "Participant Letter request" form located in Affinity under "Help Desk>Quickstart Guides". Indicate if this hospital credentialing office will need a quarterly report from Georgia PHP issued to them (March 30, June 30, Sept 30 and Dec 31st).

H. **Other State Licenses**: I am **NOT** licensed in another state: ☐

I am licensed in the following states:

State Where Licensed _____

PHP _____

PHP Contact _____

Email _____

Fax #: _____

Release Completed for State PHP ☐

State Where Licensed_____

PHP _____

PHP Contact _____

Email _____

Fax #: _____

Release Completed for State PHP ☐

State Where Licensed_____

PHP _____

PHP Contact_____

Email_____

Fax #: _____

Release Completed for State PHP ☐

State Where Licensed _____

PHP _____

PHP Contact _____

Email _____

Fax #: _____

Release Completed for State PHP ☐

_____If I move to another state before completing this agreement, I agree and endorse that the Georgia PHP, Inc. will ensure I have reported myself to the Professionals Health Program in that state. I understand that I am responsible for reporting myself to that state's program well in advance of my move as well as to notify my Georgia PHP case manager in writing via Affinity messaging.

I. Toxicology Screening Protocol:

_____I understand Georgia PHP, Inc. utilizes a Toxicology Screening Protocol that includes bodily fluids and substances. This protocol can include but is not limited to urine, hair, nail, blood, saliva or other bodily fluids or substances. (Protocol guideline available upon request.)

_____I will enroll in the Toxicology Screening Protocol to allow for random screening by the selected Georgia PHP, Inc.'s Third Party Administrator (TPA – Affinity eHealth). By my enrollment, I agree to abide by the rules and provisions of this protocol, including providing a sample when selected to do so within the parameters as set by Affinity eHealth or Georgia PHP, Inc. I understand that specimens flagged as dilute or abnormal by Georgia PHP, Inc.'s TPA- Affinity eHealth will be retested to the lowest limit of detection for substances of abuse at the discretion of the Medical Director, Executive Director or Case Manager. My account will incur additional charges for this retesting.

_____I understand I am required to check in Monday – Friday (12:30 am until 4:00pm) via the TPA-Affinity eHealth system to determine if I have been selected. I am not required to check in on weekends or the following holidays **Thanksgiving Day, Christmas Day and New Year's Day**.

_____I understand if I do not check in or test it may be considered the equivalent to a positive screen.

_____I understand in emergency situations where I may be unable to screen if selected, I should notify my Georgia PHP, Inc. Case Manager and Affinity as soon as possible; preferably within 24 hours.

_____I understand that the "incidental" consumption of alcohol or other substances (e.g. mouthwash, cleaning gel, poppy seeds) may cause a positive toxicology result that cannot be differentiated from intentional ingestion. If this situation occurs, the Georgia PHP, Inc. may require a subsequent evaluation up to and including a comprehensive 4-day evaluation.

Please refer to the Medication Guide 2012 (under My Documents in the Affinity system) *a guide to maintaining sobriety while being treated for other health problems.*

The Georgia PHP Affinity contact is Jean Spong – 877-267-4305 (press option 1 then press option 3 for Jean Spong) I will need to be in front of a computer when I activate my account.

My account must be activated by _____. I am scheduled to start checking in and testing if selected starting on _____.

J. Total Abstinence:

_____I agree to abstain completely from the use of any medications, alcohol and other mood-altering substances, including non-approved over-the-counter medications unless they are clinically indicated and prescribed by my treating physician.

_____I agree to abstain from the use of any mood-altering, addictive, or potentially addictive prescription medications, including amphetamine preparations, in all cases except medical emergencies. In the event I need to be prescribed these medications, I am required to notify my Attending Physician and my Georgia PHP, Inc. Case Manager, (if possible), prior to filing the prescription or ingesting the medication.

_____I agree to not prescribe any medication for myself, including drug company samples. I agree not to take samples or dispensed medication for any controlled substance(s). This requirement shall also apply to any care rendered to me by a dentist.

_____I agree not to prescribe, dispense or administer to family members or myself any drug having addiction-forming or addiction-sustaining liability. I understand it is the strong recommendation of the Georgia PHP, Inc. that no recovering physicians treat themselves or family members in any way.

_____I agree to follow the Georgia Composite Medical Board Rule 360-3-.02 Unprofessional Conduct Defined. This rule applies to all licensees of the Georgia Composite Medical Board.

_____I agree to contact Georgia PHP, Inc. within 24 hours in the event I: a) use alcohol or other mood-altering substances/drugs; b) have been arrested for or charged with any criminal offense; or c) have a grievance or compliant filed against me by or with the Georgia Composite Medical Board or any other agency.

_____I have been informed about the list of approved over-the-counter medications. *Please refer to the Medication Recovery Guide (under* "Help Desk>Quickstart Guides" in the Affinity system) *a guide to maintaining sobriety while being treated for other health problems.*

Short Term Use of Medication

_____In the event I have a medical condition requiring potentially addicting substance use, I agree to follow Georgia PHP, Inc.'s Short-term Use of Medication Guideline. In agreeing, I am attesting to the following:

- I will download from the Affinity site and complete the – Acute Use of Medication form.
- I will talk with my sponsor regarding use of any mood-altering medications, prescription or otherwise.
- I will talk with my Attending MD and Georgia PHP, Inc. Case Manager regarding use of any mood-altering medications, prescription or otherwise, prior to actually starting the medication.
- I will have a Medication Coach (spouse, family member, or sponsor) maintain possession of any mood-altering medication(s), and be responsible for administration and disposal of any remaining medication.
- I will inform my Georgia PHP, Inc. Case Manager as to who (Medication Coach) will hold mood-altering medications for the participant.
- I will provide copies of all prescriptions to Georgia PHP, Inc. for any mood-altering medications (via the Affinity messaging system or fax directly to Georgia PHP, Inc.) If I is am unsure as to whether a medication is mood altering, then a prescription copy should be provided to Georgia PHP, Inc. for review.
- I will provide the name and contact information of the physician that prescribes medications considered to be mood altering to Georgia PHP, Inc. I will also provide to Georgia PHP, Inc. a signed release of information allowing communication between Georgia PHP, Inc. and prescribing physician and/or pharmacist and/or my Medication Coach as appropriate.

- I will report any changes in the use of such mood-altering medications, both prescribed and over-the-counter, to my Case Manager in writing, via Affinity Messaging System, prior to such changes.
- I will inform my Attending MD and Georgia PHP, Inc. Case Manager, via the Affinity Messaging System, of any planned elective surgery and provide a list of any anticipated mood-altering medication(s) prior to such surgery.
- In the case of emergency surgery, I will inform my Attending MD and my Georgia PHP, Inc. Case Manager (as soon as possible) of the surgery and what mood-altering medications were required prior, during, or after surgery.

Note: The use of non-Georgia PHP, Inc. approved mood-altering medications (prescription or otherwise) while a participant in the Georgia PHP, Inc., may be considered a relapse and could result in additions or changes to my monitoring agreement and possibly a report of my name and condition to the GCMB. Georgia PHP, Inc. cannot advocate for participants under monitoring who are on medications that have addictive liability.

K. Travel and Vacation:

_____I agree to abide by Georgia PHP, Inc.'s Participant Travel and Vacation Guideline as follows: Georgia PHP, Inc. does not recommend travel during the first 90 days of monitoring. This restriction is to ensure I have established a strong rhythm of recovery.

_____I understand that in the event of unavoidable travel. I must submit my travel plans in writing via the Affinity system-"Monitoring Interruptions" at a minimum of two (2) weeks prior to the requested travel date. I must include:

- Date of departure and return
- Location of travel
- Lodging address
- Affinity or corresponding toxicology testing sites in the surrounding area

Participants will be notified by their Case Manager of all travel decisions including approvals, pending or denied status.

Approved travel may be approved with any of the following stipulations:

1. Continue to check in (M-F 12:30 am – 4:00 pm) and submit to toxicology screen if selected. Requires participant to have chain-of-custody (COC) forms with them; lack of appropriate forms or funding of the Affinity account are not excusable reasons for missing a toxicology screen.
2. Continue to check in (M-F 12:30 am – 4:00 pm), participant will not be selected.
3. No Check in and No testing.
4. Additional stipulations.

Missed toxicology screens during approved travel may be considered the equivalent of a positive toxicology screen.

Travel where testing sites and twelve step meetings are not readily available requires the approval of the entire Georgia PHP, Inc. team. It must be submitted via the Affinity system/Monitoring Interruptions four (4) weeks prior to requested date of travel.

In an emergency situation when unable to complete a toxicology screen, the participant shall notify their Case Manager via the Affinity Messaging System within 24 hours.

_____I understand if I enroll as an anonymous participant (one unknown to the Georgia Composite Medical Board, and other Medical Boards) I can anticipate remaining in that status unless the following occurs:

- I constitute an imminent danger to the public or myself;
- I refuse to cooperate with the Georgia PHP, Inc., refuse to submit to treatment, or am still impaired after treatment;
- It reasonably appears that there are other grounds for disciplinary action.
- I understand that any reports of sexual boundary violations with patients must be reported to the Georgia Composite Medical Board (GCMB).

_____If Georgia PHP, Inc. deems my anonymity should be broken, then I authorize the Georgia PHP, Inc. to disclose any information it may have concerning me including, but not limited to, my involvement with the Georgia PHP, Inc., my illnesses, diagnoses, prognosis, treatment, or any other information, to the GCMB, its members, employees, or agents for its use in the discharge of its duties while enforcing the laws regulating the practice of medicine and surgery and the performance of medical acts by physician assistants. The Georgia PHP, Inc. may re-disclose this information as required or permitted by Georgia law in a proceeding under Code Section 43-34-5.1 of the Georgia General Statutes.

_____I understand that I will be charged an administrative/program fee of $_____per month for the duration of this agreement. Fees may be increased at anytime with a 30 day written notice. In my first month of monitoring with Georgia PHP, Inc., I will be invoiced directly from Georgia PHP, Inc. for this fee. After the first month, my Georgia PHP, Inc. program fee will be collected via the Affinity account around the 2nd of every month. If I fail to fund my Affinity account for this fee, Georgia PHP, Inc. will charge my credit card on file to bring my account to current. The financial arrangement of this agreement is my responsibility. If at any time my account goes into arrears, I will notify the Georgia PHP, Inc. Executive Director via the Affinity Messaging System. I understand my account must be paid in full prior to completion of this agreement. Georgia PHP, Inc. does not issue refunds.

_____As a Participant, I agree to fully cooperate with my recovery monitoring. The Georgia PHP, Inc. will judiciously use all available tools to ensure as a participant, I remain in recovery and safe to practice. The tools used by Georgia PHP, Inc. include, but are not limited to drug screening of body fluids, hair, nails and other specimens, repeat evaluation, medical and psychological testing and polygraph testing.

_____I understand that Georgia PHP, Inc. may require a third party assessment of my clinical competency if there are sufficient concerns in this area.

_____I understand that adherence to this agreement is my responsibility. I understand that if I fail to comply with this agreement, the Georgia PHP, Inc., according to their approved Guidelines, may respond by:

- Encouraging me to improve my adherence.
- Changing this monitoring agreement
- Increasing my monitoring
- Extending this monitoring agreement
- Reporting me to the Georgia Composite Medical Board and any other boards relevant to my licensure, other licensing agencies, medical staff credentialing bodies, employers, malpractice carriers, other state PHP where I am licensed or seeking licensure, and other agencies. I understand that the Georgia PHP, Inc. has a duty to public safety as well as my own health.
- Making other changes in this agreement as deemed necessary by Georgia PHP, Inc.

_____I understand that if I have any concerns I can report my grievance in writing to the Georgia PHP, Inc. Executive Director via the Affinity Messaging System.

Additional Provisions as required by_____

_____

_____

_____

_____

_____

_____

_____

Participant Signature Date

Georgia PHP, Inc. Signature Date

The Georgia Professional Health Program is a non-profit 501(c)3 organization dedicated to the well-being of medical professionals in Georgia, providing confidential referral, treatment oversight, and monitoring of potentially impairing conditions, mental illnesses, and substance abuse disorders.

Our goal is to ensure the health of healthcare professionals and to ensure that they are safe to practice in their specialty. Since August 2012, the Georgia PHP has provided services for physicians, physician assistants, and respiratory therapists licensed in Georgia. Governed by a Board of Directors, the Georgia PHP maintains an active relationship with the Georgia Composite Medical Board to ensure the success of the Georgia PHP and its participants.

It is our belief that healthy professionals provide the best healthcare.

For more information on the Georgia PHP, news and events, visit gaphp.org.

Georgia PHP
Healthy Professionals, Healthy Georgia

The Highland Building
675 Seminole Avenue, Suite 108
Atlanta, Georgia 30307

Office: 678-825-3764 | Toll Free: 855-MY-GA-PHP

Georgia PHP
Healthy Professionals, Healthy Georgia

855-MY-GA-PHP | gaphp.org

Our Mission is to improve patient care and safety through early detection, treatment, and management of potentially impairing conditions in Georgia physicians and physicians assistants.

Our Objectives

- To **Educate** concerned parties, such as hospitals, medical associations, boards, and malpractice carriers about mental health and substance abuse issues among Georgia healthcare professionals
- To promote **Prevention** and early detection of these conditions through lectures, seminars, and other training venues.
- To provide **Intervention** for physicians, physician assistants, and respiratory therapists who need to enter medical care for mental health and substance abuse issues.
- To **Monitor** the status and safety of program participants once primary treatment has been completed.
- To **Coordinate** with and maintain the trust of the Georgia Composite Medical Board in order to balance participant's need for care with public safety.
- To oversee and provide **Quality Control** over the providers who offer treatment for Georgia PHP participants.
- To provide **Resources and Support** for the families of Georgia healthcare professionals monitored by the Georgia PHP.

The Georgia PHP Leadership

Paul H. Earley, M.D., FASAM
Medical Director

With more than 30 years of experience as an Addiction Medicine Physician, Dr. Paul Earley specializes in the assessment and treatment of healthcare professionals.

Dr. Earley is a nationally- and internationally-renowned speaker on the topics of addiction and treatment and has penned numerous books and articles on the subject, including "The Cocaine Recovery Book" and a chapter focused on addiction among physicians and physician health programs featured in the "Principles of Addiction Medicine," the textbook for the American Society of Addiction Medicine.

His work has been featured in the documentary series "Bill Moyers on Addiction: Close to Home," and he has championed recovery in two appearances on "The Oprah Winfrey Show." Dr. Earley serves as a Fellow of ASAM and has served on the ASAM Board of Directors for more than 12 years.

Robin McCown
Executive Director

Robin McCown is a healthcare and rehabilitation specialist with more than 25 years of experience in addiction and mental health treatment focused on outreach and referral development.

McCown has served as the Executive Director of the Georgia Chapter of the American Society of Addictive Medicine and a professional outreach coordinator for various specialty treatment facilities, also serving on the Advisory Commission of Lawyers Assistance Programs and the North Georgia EAPA Executive Board.

The Medication Guide

for a Safe Recovery

A guide to maintaining sobriety while receiving treatment for other health problems

Revision 1.6 -Sept 2013

Table of Contents

Introduction

From the Authors

Welcome to the medication guide for a safe and sustained recovery. This document was developed through a collaborative effort between some of the best minds in addiction care today and will help you make wise decisions, ensuring that medications you may be prescribed and incidental exposure to alcohol do not threaten your hard won recovery.

This guide is divided into three sections and is based on the drug classification system developed nearly 20 years ago by Paul H. Earley, M.D. and later upon by Bruce Merkin, M.D. and his associates, then at Glenbeigh Hospital. This produced Revision 1.0 of the Guide, published in 2008. This is Revision 1.4 of the guide, it contains additional medications that have since been released. In this version and going forward, medications drug safety classifications are reordered from Class A (generally safe to take) to Class C (dangerous to recovery).

The guide itself is divided into three sections. **Section One** describes the categories of medications that one may encounter, divided into the three risk categories described above. **Section Two** is a list of liquid medications that do **not** contain alcohol. **Section Three** was developed by Greg Skipper, M.D., FASAM and provides a list of common household products that contain ethyl alcohol and could produce a false positive on testing for alcohol. Avoiding these products will decrease the likelihood you will absorb or ingest small quantities of alcohol that could sensitize your system and threaten recovery.

Please remember that this guide is only intended as a quick reference and never as a substitute for the advice of your own personal addiction medicine physician or addiction psychiatrist. It is essential that you inform all of your personal physicians, dentists and other health care providers of your chemical dependency history so that medications can be prescribed safely and appropriately when they are deemed necessary. Never discontinue or make any changes in the doses of medication that you may have been prescribed. Doing so may result in unexpected problems such as withdrawal reactions, which in some cases can be life-threatening. The bottom line is that a recovering addict or alcoholic needs to become a good consumer. Remember that regaining health and creating a meaningful life is your responsibility!

Paul H. Earley, M.D., FASAM
Bruce Merkin, M.D.
Gregory Skipper, M.D., FASAM

Guide to Section One

There are many types of medications that may present a hazard to a person beginning the journey of recovery from chemical dependency. These include prescription and over-the-counter medications. The danger is not always that a recovering addict may develop a new addiction (though this certainly can happen), but that one can be led back into dependence on their drug of choice. The latest scientific research has proven that all the dependence-producing drugs act on the brain in the same way to produce addiction, despite having different effects or a different kind of "high" when taken.

In addition, if urine drug screening is part of the recovering person's continuing treatment program, use of many types of medications can result in falsely positive tests for the more highly addictive classes of drugs, resulting in negative consequences. Therefore, it is very important for a recovering person to learn about the different types of medications and drugs, as well as which ones present a special risk to continuing recovery and sobriety. The commonly available medications and drugs are divided into three classes – A, B and C – to indicate three increasing levels of risk.

Class A medications are generally safe from the point of view of addiction recovery. However, overuse of any medication, even the common over-the-counter remedies, can result in unwanted side effects. People who have struggled with drug addiction or alcoholism must remain aware of the tendency to look for external solutions for internal problems and should avoid taking any of these medications on their own in order to medicate emotions and feelings. The tools of recovery, including participation at 12-Step fellowship meetings, working the Steps, or talking with a sponsor, counselor or doctor, provide safe and healthy ways to deal with the strong feelings that can come up at any time in early sobriety.

The medications in **Class B** are also potentially dangerous, especially when taken by recovering persons without the guidance of a physician or another health care professional. However, under certain circumstances, the Class B group can be taken safely under a physician's care. We strongly urge you to have an addiction medicine specialist follow your treatment when you are prescribed these medications.

Class C drugs must be avoided if at all possible, as they are well known to produce addiction and are the most dangerous of all. Only under very unusual conditions can Class C drugs be taken by a recovering addict or alcoholic, and only when given by a physician or dentist and with the consent of the addiction medicine physician that follows your care. These exceptional circumstances can include severe illness and injuries, including major surgery, car accidents and other trauma, and tests or procedures that can only be done under sedation or anesthesia. Medication treatments for certain psychiatric conditions are in this category as are medications used for drug detoxification. The street names for relevant drugs are also included in Class C.

The three classes of medications that appear on the following pages include both the brand name (e.g. "Valium"), as well as the generic name (e.g. "diazepam"), as the majority of prescription bottles are labeled with the generic name. On the following pages, look for the brand name listed first, followed by the (generic name) in parentheses. For street drugs, the common name is listed first, and the chemical name or street name is in parentheses. For each drug group in Class B and C, there is also a brief explanation of the dangers associated with taking the medication or street drug.

Class A Drugs
Generally Safe to Take

Alzheimer's Disease & Memory Loss:
Aricept (donepezil)
Exelon (rivastigmine)
Namenda (memantine)
Razadyne (galantamine)

Analgesics (Migraine):
Amerge (naratriptan)
Axert (almotriptan)
Frova (frovatriptan)
Imitrex (sumatriptan)
Maxalt (rizatriptan)
Relpax (eletriptan)
Zomig (zolmitriptan)

Analgesics (Other):
Tylenol (acetaminophen) OTC **(also look under the heading: *Non Steroidal Anti Inflamatory Drugs*)**

Anti-Convulsants (Mood Stabilizers):
Carbatrol (carbamazepine)
Depakote (divalproex sodium)
Dilantin (phenytoin)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zonegran (zonisamide)

Antihistamines (Non-sedating):
Alavert (loratadine) OTC
Allegra (fexofenadine)
Clarinex (desloratadine)
Claritin (loratadine) OTC
Zyrtec (cetirizine)

Antibiotics/Antivirals:
Amoxil (amoxicillin)
Augmentin (amoxicillin/clavulanate)
Avelox (moxifloxacin)
Bactrim (sulfamethoxazole/trimethoprim)
Biaxin (clarithromycin)
Ceclor (ceflacor)
Ceftin (cefuroxime)
Cefzil (cefprozil)
Cipro (ciprofloxacin)
Cleocin (clindamycin)
Diflucan (fluconazole)
Doryx (doxycycline)
Duricef (cefadroxil)
E-Mycin (erythromycin)
Flagyl (metronidazole)
Keflex (cephalexin)
Ketek (telithromycin)
Levaquin (levofloxain)
Lorabid (loracarbef)
Macrobid (nitrofurantoin monohydrate)
Macrodantin (nitrofurantoin macrocrystals)
Minocin (minocycline)
Omnicef (cefdinir)
Pen-Vee K (penicillin)
Relenza (zanamavir)
Sporanox (itraconazole)
Sumycin (tetracycline)
Tamiflu (oseltamavir)
Tequin (gatifloxacin)
Valtrex (valacyclovir)
Vantin (cefpodoxime)
Vibramycin (doxycycline)
Zithromax (azithromycin)
Zovirax (acyclovir)

Class A Drugs
Generally Safe to Take

Anti-Parkinsonians:
Mirapex (pramipexole)
Requip (ropinirole)
Sinemet (carbidopa/levodopa)

Antitussives/Expectorants:
Humibid LA (guaifenesin/potassium guaiacolsulfonate)
Mucinex (guaifenesin) OTC
Tessalon Perles (benzonatate)

Asthma/COPD/Pulmonary:
Accolate (zafirlukast)
Atrovent (ipratropium)
Combivent (albuterol/ipratropium)
Proventil/Ventolin (albuterol)
Singulair (montelukast)
Spiriva (tiotropium)
Theo-24 (theophylline)
Xopenex (levalbuterol)

Benign Prostatic Hypertrophy (Also Cardiovascular):
Cardura (doxazosin)
Flomax (tamsulosin)
Hytrin (terazosin)
Proscar (finasteride)

Cardiovascular (Antihypertensives, Anticoagulants, Antiplatelets, Cholesterol Lowering, Diuretics):
Accupril (quinapril)
Aldactone (spironolactone)
Altace (ramipril)
Aspirin
Atacand (candesartan)
Avalide (irbesartan/hydrochlorothiazide)
Avapro (irbesartan)
Benicar (olmesartan)
Betapace (sotalol)
Bumex (bumetadine)
Calan (verapamil)
Cardizem (diltiazem)
Coreg (carvedilol)
Coumadin (warfarin)
Cozaar (losartan)
Crestor (rosuvastatin)
Demadex (torsemide)
Diovan (valsartan)
Dyazide (hydrochlorothiazide/triamterene)
Heparin
Hydrodiuril (hydrochlorothiazide)
Hyzaar (losartan/hydrochlorothiazide)
Imdur (isosorbide mononitrate)
Inderal (propranolol)
Isordil (isosorbide dinitrate)
Lanoxin (digoxin)
Lasix (furosemide)
Lipitor (atorvastatin)
Lopid (gemfibrozil)
Lopressor (metoprolol)
Lotensin (benazepril)
Lotrel (amlopidine/benazepril)
Lovenox (enoxaparin)
Monopril (fosinopril)
Niaspan (Niacin)
Nitro-Bid (nitroglycerin)
Norvasc (amlopidine)
Plavix (clopidogrel)
Pravachol (pravastatin)
Prinivil (lisinopril)
Sular (nisoldipine)
Tenormin (atenolol)
Tricor (fenofibrate)
Vasotec (enalapril)
Vytorin (ezetimibe/simvastatin)
Zestril (lisinopril)
Zetia (ezetimibe)
Zocor (simvastatin)

Class A Drugs
Generally Safe to Take

Diabetes Mellitus:

Actos (pioglitazone)
Amaryl (glimepiride)
Avandia (rosiglitazone)
Diabeta (glyburide)
Glucophage (metformin)
Glucotrol (glipizide)
Humalog (insulin lispro)
Humulin L,N,R,U (insulin)
Lantus (insulin glargine)
Novolin 70/30, N or R (insulin)
Novolog (insulin aspart)

Erectile Dysfunction:

Cialis (tadalafil)
Levitra (vardenafil)
Viagra (sildenafil)

Gastrointestinal (Antacids, Anti-diarrheals, Anti-Spasmosdics, Anti-Ulcers, Constipation, Nausea/ Vomiting):

Aciphex (rabeprazole)
Bentyl (dicyclomine)
Colace (docusate sodium) OTC
Emetrol (phosphorylated carbohydrate) OTC
Imodium (loperamide) OTC
Kaopectate (bismuth subsalicylate) OTC
Maalox OTC
Mylanta OTC
Nexium (esomeprazole)
Pepcid (famotidine) OTC
Pepto-Bismol (bismuth subsalicylate) OTC
Prevacid (lansoprazole)
Prilosec (omeprazole) OTC
Protonix (pantoprazole)
Reglan (metoclopramide)
Simethicone OTC
Tums OTC
Zantac (ranitidine) OTC

Genitourinary:

Detrol (tolterodine)
Ditropan (oxybutinin)

Glaucoma:

Alphagan P (brimonidine)
Azopt (brinzolamide)
Cosopt (dorzolamide/timolol)
Lumigan (bimatoprost)
Timoptic (timolol)
Travatan (travoprost)
Trusopt (dorzolamide)
Xalatan (latanoprost)

Gout:

Zyloprim (allopurinol)

Nasal Sprays:

Atrovent (ipratropium)
Ayr (saline) OTC
HuMist (saline) OTC
NaSal (saline) OTC
NasalCrom (cromolyn) OTC
Ocean Spray (saline) OTC

Class A Drugs
Generally Safe to Take

Non-Steroidal Anti-Inflammatory Drugs:

Advil (ibuprofen) OTC
Aleve (naproxen) OTC
Anaprox (naproxen)
Cataflam (diclofenac potassium)
Daypro (oxaprozin)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Motrin (ibuprofen) OTC
Naprosyn (naproxen)
Orudis (ketoprofen)
Relafen (nabumetone)
Toradol (ketorlac)
Voltaren (diclofenac sodium)

COX-2 inhibitors:

Celebrex (celecoxib)

Osteoporosis (Calcium Metabolism):

Actonel (risedronate)
Boniva (ibandronate)
Evista (raloxifene)
Fosamax (alendronate)

Antidepressants and Psychotropics:

Abilify (aripiprazole)
Buspar (buspirone)
Celexa (citalopram)
Clozaril (clozapine)
Cymbalta (duloxetine)
Depakote (divalproex sodium)
Serzone (nefazodone)
Sinequan (doxepin)
Eskalith (lithium)
Geodon (ziprasidone)
Haldol (haldoperidol)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Risperdal (risperidone)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Strattera (atomoxetine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Zyprexa (olanzapine)

See the note in Class B Psychotropics for additional information about Seroquel (quetiapine).

Sleep Aid:

Rozerem (ramelteon)

Thyroid:

Armour thyroid (thyroid desiccated)
Levothroid (levothyroxine)
Levoxyl (levothyroxine)
Synthroid (levothyroxine)

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Addiction Treatments:

NOTE: Although the medications listed in this *Addiction Treatments* section are specifically intended to be taken for medication-assisted treatment or relapse prevention for one or more drugs. Two of these medications may be habit-forming or addictive themselves and should therefore be used cautiously in recovering individuals. Their proper use in the context of a recovery program requires monitoring by a health care professional, and it is for this reason that we place them in Class B.

Antabuse (disulfiram)
Campral (acamprosate)
Catapres (clonidine)
Chantix (varenicline)
Subutex (buprenorphine)
Revia (naltrexone)
Symmetrel (amantadine)
Zyban (bupropion)
Suboxone (buprenorphine/naloxone)

Naltrexone may precipitate intense withdrawal symptoms in patients addicted to opiates. Clonidine acts via autoreceptors in the locus coeruleus to suppress adrenergic hyperactivity there that is involved in the expression of the opioid withdrawal syndrome. Disulfiram is dangerous if taken with alcohol. Amantadine can cause decreased mental alertness or altered coordination. Chantix and Zyban are medications to help with nicotine (cigarettes, cigars, chewing tobacco, snuff) addiction.

A special mention should be made about the drugs Suboxone and Subutex. These medications are used for medication-assisted treatment and are effective in caring for opioid dependence. They are commonly but not always used in the treatment of opioid addiction. Their use must be carefully monitored by an addiction medicine specialist. Discontinuing these medications at the end of a course of treatment treatment can be difficult and should be done under the care of an addiction medicine specalist.

Cough and Cold Preparations:

Antihistamines (Sedating)

Atarax (hydroxyzine hydrochloride)
Benadryl (diphenhydramine) OTC
Chlor-Trimeton (chlorpheniramine) OTC
Dimetane (brompheniramine) OTC
Efidac (chlorpheniramine) OTC
Periactin (cyproheptadine)
Polarmine (dexchlorpheniramine)
Tavist (clemastine) OTC
Teldrin (chlorpheniramine) OTC
Vistaril (hydroxyzine pamoate)

Sedating antihistamines should be used with caution because they have the potential to alter judgment and cause fatigue or sedation.

Antitussives/Expectorants

Benylin Cough (dextromethorphan) OTC
Comtrex (dextromethorphan) OTC
Contac (dextromethorphan) OTC
Delsym (dextromethorphan) OTC
Mucinex DM (dextromethorphan/guaifenesin) OTC
Nyquil (dextromethorphan/alcohol) OTC
Phenergan DM (promethazine/dextromethorphan)
Robitussin DM (dextromethorphan/guaifenesin)
Vicks Formula 44D (dextromethorphan) OTC

Any preparation containing dextromethorphan can be addictive and should be used with caution. Dextromethorphan acts on opioid receptors in the brain. Respiratory depression and perceptual distortions can also be seen in those people taking large doses.

moods or worsen mood swings.

Asthma/COPD/Pulmonary (Inhaled Corticosteroids/Long-Acting Beta 2 Agonists)

Advair Diskus (fluticasone/salmeterol)
Azmacort (traimcinolone)
Flovent (fluticasone)
Pulmicort (budesonide)
Serevent Diskus (salmeterol)
QVAR (beclomethasone)

Particular care is required when patients are transferred from systemic corticosteroids to inhaled products due to possible adrenal insufficiency or withdrawal from steroids, including an increase in allergic symptoms. Regular use may suppress the immune system. Orally-inhaled corticosteroids may cause a reduction in growth velocity in pediatric patients. Advair and Serevent can cause central nervous system excitement.

Gastrointestinal (Constipation)

Dulcolax (bisacodyl) OTC
Ex-Lax (senna) OTC
Senokot (senna) OTC

Continued use of laxatives can lead to dependency for colon function. Use for only a short period of time.

Gastrointestinal (Nausea/Vomiting)

Compazine (prochlorperazine)
Phenergan (promethazine)
Tigan (trimethobenzamide)
Zofran (ondansetron)

These medications affect the central nervous system and can cause sedation.

Vertigo/Motion Sickness

Antivert (meclizine)
Dramamine (dimenhydrinate) OTC
Transderm Scop (scopolamine)

These medications affect the central nervous system and can cause dizziness, drowsiness or blurred vision.

Narcolepsy / Hypersomnia

ProVigil (modafinil)
Nuvigil (armodafinil)

The newer agents for maintaining wakefulness are safer than the amphetamine-class of drugs. However, they should not be used with patients who simply need to stay awake. Recovering individuals are sensitive to sleep problems and these medications should be avoided for rotating shift workers is at all possible. Many recovering individuals have difficulty tolerating rotating shift work.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Decongestants (Many are Combination Products)

Actifed (pseudoephedrine/triprolidine) OTC
AH-chew D (phenylephrine) OTC
Alavert D (loratadine/pseudoephedrine) OTC
Allegra D (fexofenadine/pseudoephedrine)
Benzedrex Nasal Inhaler (propylhexamine) OTC
Bromfed (phenylephrine/brompheniramine)
Bromfed DM (pseudoephedrine/ brompheniramine/dextromethorphan)
Cardec DM (pseudoephedrine/ carbinoxamine/dextromethorphan)
Clarinex D (desloratadine/pseudoephedrine)
Claritin D (loratadine/pseudoephedrine) OTC
Deconamine SR (pseudoephedrine/ chlorpheniramine) OTC
Dimetapp (pseudoephedrine/brompheniramine) OTC
Duratuss (pseudoephedrine/guaifenesin)
Entex LA (phenylephrine/guaifenesin)
Entex PSE (pseudoephedrine/guaifenesin)
Humibid DM (pseudoephedrine/ dextromethorphan/ potassium guaiacolsulfonate)
Mucinex D (pseudoephedrine/guaifenesin) OTC
Nalex-A (phenylephrine) OTC
Novafed (pseudoephedrine) OTC
Profen (pseudoephedrine) OTC
Prolex-D (phenylephrine) OTC
R-Tannate Pediatric (phenylephrine/ chlorpheniramine/pyrilamine)
Rondec (phenylephrine/chlorpheniramine)
Rondec DM (phenylephrine/chlorpheniramine/ dextromethorphan)
Rynatan-S (phenylephrine/chlorpheniramine/ pyrilamine)
Semprex-D (pseudoephedrine/acrivastine)
Sinutuss DM (phenylephrine) OTC
Sudafed (pseudoephedrine) OTC
Tussafed-EX (phenylephrine) OTC
Zyrtec D (cetirizine/pseudoephedrine)

Decongestants should be used with caution because they are stimulating and can trigger relapse.

Psychotropics

Seroquel (quetiapine)

Many addiction medicine practioners have noticed that some addicted individuals tend to over-use or even abuse Seroquel (quetiapine). Others seem to take the medication without problems. Therefore, we have placed this medication on in Class B.

Nasal Sprays

Afrin (oxymetazoline) OTC
Astelin (azelastine)
Dristan (oxymetazoline) OTC
Flonase (fluticasone)
Nasacort AQ or HFA (triamcinolone)
Nasonex (mometasone)
Neo-synephrine (phenylephrine) OTC
Nostrilla (oxymetazoline) OTC
Rhinocort Aqua (budesonide)
Vicks Nasal Inhaler (desoxyephedrine) OTC
Vicks Sinex (phenylephrine) OTC
4-Way Nasal Spray (phenylephrine) OTC

All OTC nasal sprays should be used for a short period of time. If used for a long period of time symptoms may worsen. Use for a maximum of 5 days. Intranasal corticosteroids (non-OTC) may cause a reduction in growth velocity in pediatric patients.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Muscle Relaxants:

Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Parafon Forte (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Zanaflex (tizanidine)

Muscle relaxants can cause central nervous system depression (sedation, dizziness), which may impair physical or mental abilities.

Anticonvulsants and Neuropathic Pain:

Lyrica (pregabalin)
Neurontin (gabapentin)

Lyrica acts in the central nervous system as a depressant and can lead to withdrawal symptoms upon discontinuation. It also produces euphoria in certain individuals and therefore should be used with caution. Recent case reports suggest that it may be addictive in some individuals. Gabapentin is useful in chronic pain, mood stability and anxiety disorders in recovering individuals. Clinical experience has shown that gabapentin can also be abused by recovering individuals; its use should monitored.

Sleep Aids:

Excedrin PM (diphenhydramine) OTC
Nytol (diphenhydramine) OTC
Sleep-eze (diphenhydramine) OTC
Sominex (diphenhydramine) OTC
Tylenol PM (diphenhydramine/acetaminophen) OTC
Unisom (diphenhydramine) OTC

Sleep aids act in the central nervous system and can alter judgement and cause sedation. In general addiction medicine physicians prefer known prescription agents that help with sleep and do not increase the probability of relapse.

Others:

Asthma

Primatene Mist (epinephrine) OTC

Primatene Mist can cause nervousness, restlessness, sleeplessness, palpitations, tachycardia, chest pain, muscle tremors, dizziness and flushing.

Catabolic Steroids

Decadron (dexamethasone)
Deltasone (prednisone)
Medrol (methylprednisolone)

It is important to take catabolic steroids exactly as directed. These compounds are not the same type of steroids that atheletes take to build muscle mass. If catabolic steroids are used for a long time, you may need to taper them when they are no longer needed. Steroid use can decrease the immune system leading to increased infections. Insomnia, nervousness and a variety of other side effects are also common. Some people may find catabolic steroids exacerbate high or low

Class C Drugs

High Risk of Triggering Relapse

Alcohol:

Ale
Beer (including "non-alcoholic" forms)
Brandy
Liqueur
Malt Beverage
Whiskey
Wine
Wine Cooler

Alcohol consumption reduces social inhibitions and produces pleasure and a sense of well-being. It is a stimulant (raises blood pressure and heart rate) and a depressant. Alcohol affects the brain's reward pathways and appears to be related to interactions with dopamine, GABA, serotonin, opioid and NMDA neurotransmitter systems. The "non-alcohol" or "NA" forms of beer should not be consumed because there is a small amount of alcohol present and research shows that smell may be enough to trigger cravings and a subsequent relapse among certain alcoholics. Please note that there is a variety of cough and cold preparations that contain alcohol and that medications which can be taken in tablet form will not contain ethyl alcohol. Certain topical products, soft-gels and capsules contain ethyl alcohol and should be avoided. Please refer to the table at the end of the document for a list of alcohol-containing products to avoid.

Antitussives/Expectorants:

Ambenyl (codeine/bromodiphenhydramine)
Duratuss HD (hydrocodone/dextromethorphan)
Guiatuss (codeine/pseudoephedrine/guaifenesin)
Hycodan Tablets (hydrocodone/homatropine)
Hycodan Syrup (hydrocodone/homatropine)
Hycomine (hydrocodone/chlorpheniramine/ phenylephrine/acetaminophen/caffeine)
Vicodin Tuss (hydrocodone/guaifenesin)
Hydromet (hydrocodone/homatropine)
Mytussin (codeine/pseudoephedrine/guaifenesin)
Nucofed (codeine/pseudoephedrine/guaifenesin)
Phenergan with Codeine (codeine/promethazine)
Robitussin AC (codeine/guaifenesin)
Tussionex PennKinetic (hydrocodone/ chlorpheniramine)
Hycotuss (hydrocodone/guaifenesin)

Any cough medications containing narcotics such as codeine or hydrocodone should not be used. These medications bind to opiate receptors in the central nervous system, altering the perception of and response to pain and produce generalized central nervous system depression and may alter mood or cause sedation.

Barbiturates:

Amytal (amobarbital)
Barbita (phenobarbital)
Butisol (butabarbital)
Donnatal (phenobarbital/atropine/hyoscyamine/ scopolamine)
Esgic (acetaminophen/butalbital/caffeine)
Fioricet (butalbital/acetaminophen/caffeine)
Fiorinal (butalbital/aspirin/ caffeine)
Nembutal (pentobarbital)
Seconal (secobarbital)

These medications can produce central nervous system depression ranging from mild (sedation) to hypnotic (sleep induction). As the dose is increased, coma and death can occur. These medications can also lead to an unusual excitatory response in some people.

Class C Drugs

High Risk of Triggering Relapse

Benzodiazepines:

Ativan (lorazepam)
Centrax (prazepam)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Restoril (temazepam)
Serax (oxazepam)
Tranxene (chlorazepate)
Valium (diazepam)
Versed (midazolam)
Xanax (alprazolam)

These medications can produce an immediate change in mood or affect and can cause central nervous system depression (dose related) resulting in sedation, dizziness, confusion or ataxia, which may impair physical and mental capabilities. Abrupt discontinuation or a large decrease in dose can lead to seizures, coma or death.

Hallucinogens:

Cannabis (grass, green marijuana, pot, weed)
DMT (dimethyltryptamine)
Ketamine (special K)
LSD (acid, blotter, paper, sunshine, window pane)
Marinol (dronabinol)
MDMA (E, eckies, ecstasy, love drug, X, XTC)
Mescaline (peyote)
PCP (angel dust, phencyclidine)
Psilocybin (magic mushroom, 'shrooms)
2-CB
5-MeO-DIPT (foxy methoxy)
STP (DOM)

Hallucinogens act in the central nervous system. Using these substances can possibly lead to memory disturbances, psychosis and vivid hallucinations. Marinol is the psychoactive substance in marijuana and may cause withdrawal symptoms if stopped suddenly.

Inhalants:

Aerosols (hair sprays, deodorants)
Airplane Glue
Amyl Nitrate (poppers)
Butyl Nitrate (room deodorizer)
Gases (ether, chloroform, nitrous oxide, butane lighters, propane tanks, whipped cream dispensers)
Nail Polish Remover (acetone)
Paint (butane, propane, toluene)
Solvents (paint thinner, gasoline, glue, correction fluid, felt tip marker)
Varnish (xylene, toluene)

Inhalants are central nervous system depressants. Use of inhalants can cause sedation and loss of inhibitions, possibly leading to liver, kidney, nerve, heart, brain, throat, nasal and lung damage up to and including coma and death.

Class C Drugs

High Risk of Triggering Relapse

Opioids:

Actiq (fentanyl oral transmucosal)
Buprenex (buprenorphine)
Combunox (oxycodone/ibuprofen)
Darvocet (propoxyphene napsylate/acetaminophen)
Darvon (propoxyphene hydrochloride)
Demerol (meperidine)
Dilaudid (hydromorphone)
Dolophine (methadone)
Duragesic (fentanyl transdermal)
Endocet (oxycodone/acetaminophen)
Heroin (down, H, horse, smack)
Kadian (morphine sulfate)
Lorcet (hydrocodone/acetaminophen)
Lortab (hydrocodone/acetaminophen)
Methadose (methadone)
MS Contin (morphine sulfate)
Norco (hydrocodone/acetaminophen)
Nubain (nalbuphine HCl)
OxyContin (oxycodone)
OxyIR (oxycodone)
Percocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Roxanol (morphine sulfate)
Roxicet (oxycodone/acetaminophen)
Roxicodone (oxycodone)
Soma Compound with Codeine (codeine/carisoprodol/aspirin)
Stadol (butorphanol)
Suboxone (buprenorphine/naloxone)
Subutex (buprenorphine)
Talacen (pentazocine/acetaminophen)
Talwin (pentazocine lactate)
Tylenol #2, #3 or #4 (codeine/acetaminophen)
Ultram (tramadol)
Vicodin (hydrocodone/acetaminophen)

Opioids bind to opiate receptors in the central nervous system causing inhibition of ascending pain pathways and altering the perception of and response to pain. Generalized central nervous system depression is also produced. Tolerance or drug dependence may result from extended use. Buprenorphine binds to mu receptors in the brain leading to a suppression of withdrawal and cravings but also feeling of euphoria. Most of the drugs in this class have the potential for drug dependency and abrupt cessation may precipitate withdrawal.

Gastrointestinal (Anti-Diarrheals):

Lomotil (atropine/diphenoxylate)
Motofen (atropine/difenoxin)

Diphenoxylate is a member of the opioid class of drugs. Atropine is added to discourage abuse for recreational purposes. At recommended doses, the atropine causes no effects but in larger doses, unpleasant symptoms are experienced. These medications should not be used because high doses may cause physical and psychological dependence with prolonged use.

Other Central Nervous System Depressants:

GH, GBL (G, gamma-hydroxybutyrate, everclear)

This category depresses the central nervous system possibly leading to confusion, psychosis, paranoia, hallucinations, agitation, depression, seizures, respiratory depression, decreases in level of consciousness, coma and death.

Class C Drugs

High Risk of Triggering Relapse

Other Sedative-Hypnotics:

Ambien (zolpidem)
Doriden (glutethimide)
Librax (chlordiazepoxide/clidinium)
Lunesta (eszopiclone)
Midrin (acetaminophen/dichloralphenazone/ isometheptene)
Miltown (meprobamate)
Somnote, Chloralum (chloral hydrate)
Placidyl (ethchlorvynol)
Quaalude, Sopor (methaqualone)
Soma (carisoprodol)
Soma Compound (carisoprodol/aspirin)
Sonata (zaleplon)
Xyrem (sodium oxybate)

These drugs act on the central nervous system and have the potential for drug dependency and abuse. Withdrawal symptoms can be seen if stopped suddenly.

Stimulants:

Adderall (amphetamine/dextroamphetamine)
Adipex-P (phentermine)
Cocaine (blow, coke, crack, rock, snow)
ConConcerta (methylphenidate)
Cylert (pemoline)
Dexedrine (dextroamphetamine)
Dextrostat (dextroamphetamine)
Fastin (phentermine)
Focalin (dexmethylphenidate)
Meridia (sibutramine)
Metadate (methylphenidate)
Methamphetamine (crank, crystal meth, glass, ice)
Methylin (methylphenidate)
Preludin (phenmetrazine)
ProCentra (dextroamphetamine)
Quillivant XR (methylphenidate)
Ritalin (methylphenidate)
Tenuate (diethylpropion)
Vyvanse (lisdexamfetamine dimesylate)

Stimulants cause physical and psychological addiction, impair memory and learning, hearing and seeing, speed of information processing, and problem-solving ability. Some stimulants are used to treat Attention Deficit Hyperactivity Disorder (ADHD). We recommend that patients with an addiction disorder and ADHD avoid using the drugs listed above if at all possible. A specialist in the treatment of ADHD in addicted individuals will have to weigh the potential benefits of the use of ADHD stimulants against the risk of relapse into addiction.

Section Two

Liquid medications that contain no alcohol

Guide to Section Two

When you need to take medications in a liquid form or are choosing medications to keep in your home for others, it is safest to select medications that do not contain alcohol. Many experts in the field have heard stories about patients in recovery who "took their child's liquid decongestant late at night" when they could not sleep due to cold symptoms. Prepare ahead for such events by purchasing medications for the household that do not contain alcohol.

It is surprising how many over-the-counter remedies and even "natural remedies" that contain alcohol. Clinical experience has shown that individuals recovering from addiction are at times subtly triggered by even small amounts of alcohol.

The list is not comprehensive. Manufacturers change product ingredients and brand names frequently. Always check product labeling for definitive information on specific ingredients. Manufacturers are listed after each product name. Please note that some of these medications, while alcohol-free, do contain compounds with addiction liability and are thus Class B medications. Such products are preceded by an asterisk (*).

Choose from this list whenever possible. If you are not sure, read the label!

Alcohol-Free Products

Analgesics:

Acetaminophen Infants Drops	**Ivax**
Actamin Maximum Strength Liquid (acetaminophen)	**Cypress**
Addaprin Tablet (ibuprofen)	**Dover**
Advil Children's Suspension (ibuprofen)	**Wyeth Consumer**
Aminofen Tablet (acetaminophen)	**Dover**
Aminofen Max Tablet (acetaminophen)	**Dover**
APAP Elixir (acetaminophen)	**Bio-Pharm**
Aspirtab Tablet (aspirin)	**Dover**
Genapap Children Elixir (acetaminophen)	**Ivax**
Genapap Infant's Drops (acetaminophen)	**Ivax**
Motrin Children's Suspension (ibuprofen)	**McNeil Consumer**
Motrin Infants' Suspension (ibuprofen)	**McNeil Consumer**
Silapap Children's Elixir (acetaminophen)	**Silarx**
Silapap Infant's Drops (acetaminophen)	**Silarx**
Tylenol Children's Suspension (acetaminophen)	**McNeil Consumer**
Tylenol Extra Strength Solution (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Drops (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Suspension (acetaminophen)	**McNeil Consumer**

Anti-Asthmatic Agents:

Dilor-G Liquid (guaifenesin/dyphylline)	**Savage**
Elixophyllin-GG liquid (guaifenesin/theophylline)	**Forest**

Anti-Convulsants:

Zarontin Syrup (Ethosuximide)	**Pfizer**

Antiviral Agents:

Epivir Oral Solution (Lamivudine)	**GlaxoSmithKline**

Cough/Cold/Allergy Preparations:

***Accuhist Pediatric Drops** (brompheniramine/pseudoephedrine)	**Propst**
***Alka Seltzer Plus Day Cold** (acetaminophen, dextromethorphan, phenylephrine)	**Bayer**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Alka Seltzer Plus Night Cold** (acetaminophen, dextromethorphan, phenylephrine, chlorpheniramine, doxylamine)	**Bayer**
***Allergy Relief Medicine Children's Elixir** (diphenhydramine)	**Hi-Tech Pharmacal**
***Andehist DM Drops** (carbinoxamine/ dextromethorphan)	**Cypress**
***Andehist DM Syrup** (carbinoxamine/ dextromethorphan)	**Cypress**
***Andehist DM NR Liquid** (carbinoxamine/dextromethorphan/pseudoephedrine)	**Cypress**
***Andehist DM NR Syrup** (carbinoxamine/dextromethorphan/pseudoephedrine)	**Cypress**
***Andehist NR Syrup** (carbinoxamine/pseudoephedrine)	**Cypress**
***Bayer Alka Seltzer Plus Cold & Cough** (acetaminophen, dextromethrophan, phenylephrine, chlorpheniramine)	**Bayer**
***Benadryl Allergy Solution** (diphenhydramine)	**Pfizer Consumer**
***Biodec DM Drops** (carbinoxamine/dextromethorphan/pseudoephedrine)	**Bio-Pharm**
***Biodec DM Syrup** (carbinoxamine/dextromethorphan/pseudoephedrine)	**Bio-Pharm**
***Broncotron Liquid** (pseudoephedrine)	**Seyer Pharmatec**
***Buckleys Mixture,** (dextromethorphan)	**Novartis**
Carbatuss Liquid (phenylephrine/guaifenesin)	**GM**
Cepacol Sore Throat Liquid (benzocaine)	**J.B. Williams**
***Children's Benadryl Allergy,** (diphenhydramine)	**Pfizer**
***Chlor-Trimeton Allergy Syrup** (chlorpheniramine)	**Schering Plough**
***Codal-DM Syrup** (dextromethorphan/phenylephrine/pyrilamine)	**Cypress**
***Creomulsion Complete Syrup** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Summit Industries**
***Creomulsion Cough Syrup** (dextromethorphan)	**Summit Industries**
***Creomulsion For Children Syrup** (dextromethorphan)	**Summit Industries**
***Creomulsion Pediatric Syrup** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Summit Industries**
***Delsym Cough Suppressant** (dextromethorphan)	**Cell Tech**
***Despec Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin/phenylephrine)	**International Ethical**
***Diabetic Tussin Allergy Relief Liquid** (chlorpheniramine)	**Healthcare Products**
***Diabetic Tussin DM Liquid** (guaifenesin/dextromethorphan)	**Healthcare Products**
***Diabetic Tussin DM Maximum Strength Liquid** (guaifenesin/dextromethorphan)	**Healthcare Products**
***Diabetic Tussin DM Maximum Strength Capsule** (guaifenesin/dextromethorphan)	**Healthcare Products**
Diabetic Tussin EX Liquid (guaifenesin)	**Healthcare Products**
***Diabetic Tussin Nighttime Formula Cold/Flu Relief** (dextromethrophan, acetaminophen, diphenhydramine)	**Healthcare Products**
***Dimetapp Cold & Fever Children's Suspension** (ibuprofen/pseudoephedrine)	**Wyeth Consumer**
***Double-Tussin DM Liquid** (guaifenesin/dextromethorphan)	**Reese**
***Dynatuss Syrup** (carbinoxamine/pseudoephedrine/dextromethorphan)	**Breckenridge**
***Dynatuss EX Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	**Breckenridge**
***Entex Syrup** (phenylephrine/guaifenesin)	**Andrx**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Father John's Medicine Plus Drops** (chlorpheniramine/ phenylephrine/ dextromethorphan/ guaifenesin/ammonium chloride)	**Oakhurst**
***Friallergia DM Liquid** (brompheniramine/pseudoephedrine/dextromethorphan)	**R.I.D.**
***Friallergia Liquid** (brompheniramine/pseudoephedrine)	**R.I.D.**
***Gani-Tuss-DM NR Liquid** (guaifenesin/dextromethorphan)	**Cypress**
***Genahist Elixir** (diphenhydramine)	**Ivax**
***Giltuss Pediatric Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Giltuss Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Guaicon DMS Liquid** (guaifenesin/dextromethorphan)	**Textilease Medique**
***Guai-Dex Liquid** (guaifenesin/dextromethorphan)	**Alphagen**
***Guaifed Syrup** (phenylephrine/pseudoephedrine/guaifenesin)	**Muro**
***Hayfebrol Liquid** (chlorpheniramine/pseudoephedrine)	**Scot-Tussin**
***Histex Liquid** (chlorpheniramine/pseudoephedrine)	**TEAMM**
Histex PD Drops (carbinoxamine)	**TEAMM**
Histex PD Liquid (carbinoxamine)	**TEAMM**
***Hydramine Elixir**(diphenhydramine)	**Ivax**
***Hydro-Tussin DM Elixir** (guaifenesin/dextromethorphan)	
***Kita La Tos Liquid** (guaifenesin/dextromethorphan)	**R.I.D.**
***Lodrane Liquid** (brompheniramine/pseudoephedrine)	**ECR**
***Medi-Brom Elixir** (brompheniramine/pseudoephedrine/dextromethorphan)	**Medicine Shoppe**
***Motrin Cold Children's Suspension** (ibuprofen/pseudoephedrine)	**McNeil Consumer**
***Nalex-A Liquid** (chlorpheniramine/phenylephrine)	**Blansett Pharmacal**
***Nalspan Senior DX Liquid** (guaifenesin/dextromethorphan)	**Morton Grove**
***Neotuss-D Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**A.G. Marin**
***Norel DM Liquid** (chlorpheniramine/phenylephrine/ dextromethorphan)	**U.S. Pharmaceutical**
Orgadin Liquid (guaifenesin)	**American Generics**
Organidin NR Liquid (guaifenesin)	**Wallace**
***Palgic-DS Syrup** (carbinoxamine/pseudoephedrine)	**Pamlab**
***Panmist DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	**Pamlab**
***Panmist-S Syrup** (guaifenesin/pseudoephedrine)	**Pamlab**
***PediaCare Cold + Allergy Children's Liquid** (chlorpheniramine/pseudoephedrine)	**Pharmacia**
***PediaCare Cough + Cold Children's Liquid** (chlorpheniramine/ pseudoephedrine/ dextromethorphan)	**Pharmacia**
***PediaCare Nightrest Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Pharmacia**
***Pediahist DM Syrup** (brompheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**Boca**
***Pedia-Relief Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Major**
Pediatex Liquid (carbinoxamine)	**Zyber**
***Pediatex-D Liquid** (carbinoxamine/pseudoephedrine)	**Zyber**
Phanasin Syrup (guaifenesin)	**Pharmakon**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

Phanatuss Syrup (guaifenesin)	**Pharmakon**
***Phena-S Liquid** (chlorpheniramine/phenylephrine)	**GM**
***Poly-Tussin DM Syrup** (chlorpheniramine/phenylephrine/dextromethorphan)	**Poly**
***Primsol Solution**(trimethoprim)	**Medicis**
***Prolex DM Liquid** (guaifenesin/dextromethorphan)	**Blansett Pharmacal**
***Quintex Syrup** (phenylephrine/guaifenesin)	**Qualitest**
***Robitussin Cough & Congestion Liquid** (chlorpheniramine/pseudoephedrine/ dextromethorphan/guaifenesin/acetaminophen)	**Wyeth Consumer**
***Robitussin Cough & Cold Nightime** (chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin Cough & Allergy** (chlorpheniramine, dextromethorphan, phenylephrine	**Wyeth**
***Robitussin Cough & Cold CF** (dextromethorphan, guaifenesin, phenylephrine)	**Wyeth**
***Robtiussin Cold & Flu Nightime** (acetaminophen, chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin DM Liquid** (guaifenesin/dextromethorphan)	**Wyeth Consumer**
***Robitussin PE Syrup** (pseudoephedrine/guaifenesin)	**Wyeth Consumer**
***Robitussin Pediatric Drops** (guaifenesin/dextromethorphan/pseudoephedrine)	**Wyeth Consumer**
***Robitussin Pediatric Night Relief Liquid** (chlorpheniramine/dextromethorphan/ pseudoephedrine)	**Wyeth Consumer**
***Scot-Tussin Allergy Relief Formula Liquid** (diphenhydramine)	**Scot-Tussin**
***Scot-Tussin DM Liquid** (chlorpheniramine/dextromethorphan/guaifenesin)	**Scot-Tussin**
***Scot-Tussin Expectorant Liquid** (guaifenesin)	**Scot-Tussin**
***Scot-Tussin Original Syrup** (phenylephrine)	**Scot-Tussin**
***Scot-Tussin Senior Liquid** (guaifenesin/dextromethorphan)	**Scot-Tussin**
***Sildec Liquid** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec Syrup** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec-DM Drops** (brompheniramine/pseudoephedrine/carbinoxamine/dextromethorphan)	**Silarx**
***Sildec-DM Syrup** (brompheniramine/pseudoephedrine/ carbinoxamine/dextromethorphan)	**Silarx**
Siltussin DAS Liquid (guaifenesin)	**Silarx**
***Siltussin DM Syrup** (guaifenesin/dextromethorphan)	**Silarx**
***Siltussin DM DAS Cough Formula Syrup** (guaifenesin/dextromehtorphan)	**Silarx**
Siltussin SA Syrup (guaifenesin)	**Silarx**
***Simply Cough Liquid** (dextromehtorphan)	**McNeil Consumer**
***Sudatuss DM Syrup** (chlorpheniramine/dextromethorphan/pseudoephedrine)	**Pharmaceutical Generic**
***Tussafed Syrup** (chlorpheniramine/carbinoxamine/ pseudoephedrine/dextromethorphan)	**Everett**
***Tussafed-EX Syrup** (pseudoephedrine/dextromethorphan/guaifenesin)	**Everett**
***Tuss-DM Liquid** (chlorpheniramine/phenylephrine/guaifenesin/dextromethorphan	**Seatrace**
***Tussi-Organidin DM NR Liquid** (guaifenesin/dextromethorphan)	**Wallace**
***Tussi-Pres Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Kramer-Novis**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Tylenol Cold Children's Liquid** (chlorpheniramine/pseudoephedrine/acetaminophen)	McNeil Consumer
***Tylenol Cold Infants' Drops** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Tylenol Flu Children's Suspension** (chlorpheniramine/pseudoephedrine/ dextromethorphan/acetaminophen)	McNeil Consumer
***Tylenol Flu Night Time Max Strength Liquid** (acetaminophen/ doxylamine/ diphenhydramine/pseudoephedrine/dextromethorphan)	McNeil Consumer
***Tylenol Sinus Children's Liquid** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Vicks Dayquil Multi-symptom cold/flu relief** (acetaminophen, dextromethorphan, phenylephrine)	Procter & Gamble
***Vicks 44E Pediatric Liquid** (guaifenesin/dextromethorphan)	Procter & Gamble
***Vicks 44M Pediatric Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	Procter & Gamble
***Z-Cof DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	Zyber

Ear/Nose/Throat Products:

4-Way Saline Moisturizing Mist Spray	Bristol-Myers
Ayr Baby Saline Spray	Ascher, B.F.
Bucalcide Solution (benzocaine)	Seyer Pharmatec
Bucalcide Spray (benzocaine)	Seyer Pharmatec
Bucalsep Solution (benzocaine)	Gil
Bucalsep Spray (benzocaine)	Gil
Cepacol Sore Throat Liquid (benzocaine)	Combe
Gly-oxide Liquid (carbamide peroxide)	GlaxoSmithKline
Consumer Orasept Mouthwash/Gargle Liquid (benzocaine)	Pharmakon Labs
Zilactin Baby Extra Strength Gel (benzocaine)	Zila Consumer

Gastrointestinal Agents

Imogen Liquid (loperamide)	Pharmaceutical
Kaopectate (bismuth subsalicyate)	Ethex

Generic

Kaopectate Suspension (bismuth subsalicylate)	Pharmacia

Consumer

Liqui-Doss Liquid (mineral oil)	Ferndale

Hematinics

Irofol Liquid (iron)	Dayton

Alcohol-Free Products

Miscellaneous

Cytra-2 Solution (sodium citrate salts)	Cypress
Cytra-K Solution (sodium citrate salts)	Cypress
Emetrol Solution (phosphorated carbohydrate)	Pharmacia Consumer

Psychotropics

***Thorazine Syrup** (chlorpromazine)	GlaxoSmithKline

Topical Products

Aloe Vesta 2-N-1 Antifungal Ointment (miconazole)	Convatec
Fleet Pain Relief Pads (pramoxine)	Fleet
Neutrogena Acne Wash Liquid	Neutrogena
Neutrogena Antiseptic Liquid	Neutrogena
Neutrogena Clear Pore Gel	Neutrogena
Neutrogena T/Derm Liquid	Neutrogena
Neutrogena Toner Liquid	Neutrogena
Podiclens Spray (benzalkonium chloride)	Woodward
Sea Breeze Foaming Face Wash Gel	Clairol

Vitamins/Minerals/Supplements

Apetigen Elixir (vitamins A & E/multivitamin)	Pharmaceutical Generic
Genesupp-500 Liquid (multivitamin)	Pharmaceutical Generic
Genetect Plus Liquid (multivitamin/iron)	Pharmaceutical Generic
Multi-Delyn w/Iron Liquid (multivitamin/iron)	Silarx
Poly-Vi-Sol Drops (multivitamin)	Mead Johnson
Poly-Vi-Sol w/Iron Drops (multivitamin/iron)	Mead Johnson
Strovite Forte Syrup (multivitamin/iron/folic acid)	Everett
Supervite Liquid (multivitamin/B complex/folic acid/multivitamin)	Seyer Pharmatec
Suplevit Liquid (multivitamin/iron)	Gil
Tri-Vi-Sol Drops (multivitamin)	Mead Johnson
Tri-Vi-Sol w/Iron Drops (multivitamin/iron)	Mead Johnson
Vitafol Syrup (multivitamin/iron/folic acid/vitamin E/calcium salts)	Everett

Section Three

Avoiding Incidental Exposure to Alcohol

New markers for alcohol use, ethylglucuronide (EtG), ethylsulfate (EtS) and others, have added tremendous value to routine drug testing by their capacity to better document abstinence (allowing for more authoritative advocacy) and sensitively to detect early relapse (allowing for earlier assistance). Since these new markers are highly sensitive, it's important that individuals being tested try to avoid exposure to products containing alcohol that might cause positive tests. This issue is identical to that of avoiding poppy seeds to avoid a positive test for morphine. However, there are many more products containing alcohol.

Please note that this list is not exhaustive, therefore it is recommended that patients check labels or with manufacturers before using.

Possible Sources of Incidental Exposure

Foods

Foods can contain trace amounts or large quantities of alcohol. Avoid desserts and other foods cooked with or containing alcoholic beverages such as vodka, sherry, wine, etc. Also avoid foods containing significant amounts of vanilla extract (especially if added to drinks), wine vinegar, soy sauces and other condiments with alcohol content on their labels.

Hygiene Products

Many hygiene related products, such as mouthwashes, contain alcohol and should be avoided. For a comprehensive list of hygiene products that contain alcohol, please read the Alcohol-Containing Products Table on the following pages.

Over-the-Counter (OTC) Medications

Over-the-counter medications, such as cough syrup and tinctures, contain alcohol and should be avoided. Please review the *Alcohol Content of Over-the-Counter Medications* on the following pages for a more detailed breakdown of OTCs that contain alcohol.

Prescription Medications

Many prescription medications, including asthma inhalers, contain alcohol or ethanol. Always ask your health care provider prior to taking any prescription medications.

Other Sources of Alcohol

Alcohol can be found in many common products including communion wine and "alcohol-free" beer and wine. Recovering patients should also avoid products like hand sanitizers, deodorant sprays, cosmetics and insecticides that contain ethanol vapor and can be inhaled or absorbed through skin application.

Alcohol-Containing Products Table

The following is a list of products and their alcohol contents. Not all of these would actually be likely to be sources of incidental exposure and some would result in very toxic effects if there was much exposure (i.e. Clorox).

Product	*Alcohol %*
ABIN Primer & Sealer	35
Afta After Shave Skin Conditioner 3 OZ.	5-15
Afta Pre-Electric Shave Lotions	50-60
Ajax Antibacterial Dishwashing Liquid 19 OZ.	5-10
Ajax Dishwashing Liquid Antibacterial Hand Soap 38 OZ.	1-5
Aqua Mix Laminate Plus	<9
Aqua Mix Tile Plus More Cleaner-10/31/2000	<9
Ariel Liquid Laundry Detergent	1-5
Armor All Odor Eliminator	3-7
Armor All Odor Eliminator-01/01/2001	1-10
Arrid Total Gel-All Scents	7-12
Avon Black Suede After Shave	60-98
Avon Black Suede Cologne Spray	60-98
Avon Clearskin Targeted Blemish Remover	9.995
Avon Dreamlife Eau de Parfum Spray	60-98
Avon Far Away Sensual Embrace Eau de Parfum Spray	60-98
Avon Ginger Scents Spray Ginger Fresh Body Mist	60-98
Avon Haiku Eau de Parfum Spray	60-98
Avon Imari Eau de Cologne Spray	60-98
Avon Intrigue Cologne Spray	60-98
Avon Lil Hugs Gentle Splash	60-98
Avon Little Black Dress Eau de Parfum Spray	60-98
Avon Memorable Eau de Parfum Spray	60-98
Avon Mesmerize for Men Cologne Spray	60-98
Avon Midnight Frost Fragrance Spray	60-98
Avon Moisture Effective Eye Makeup Remover Lotion	60-98
Avon MUSK FOR BOYS	60-98
Avon NAIL EXPERTS Strong Results	21.74
Avon NATURALS Body Spray, Almond	60-98
Avon NATURALS Body Spray, Cucumber Melon	60-98
Avon NATURALS Body Spray, Gardenia	60-98
Avon NATURALS Body Spray, Lily	60-98
Avon NATURALS Body Spray, Peach	60-98
Avon NATURALS Body Spray, Plumeria	60-98
Avon NATURALS Body Spray, Raspberry	60-98

Incidental Alcohol Exposure

Alcohol-Containing Products

Product	*Alcohol %*
Avon NATURALS Body Spray, Sea	60-98
Avon NATURALS Body Spray, Vanilla	60-98
Avon Night Evening Magic Cologne Spray	60-98
Avon Passion Dance for Men	60-98
Avon Passion Dance for Women	60-98
Avon Perceive Eau de Parfum Spray for Women	60-98
Avon Perceive For Men Cologne Spray	60-98
Avon Pink Suede Eau de Toilette Spray	60-98
Avon Planet Spa White Tea Energizing Face and Body Mist	60-98
Avon Prospect Eau de Toilette Spray	60-98
Avon Radiant Moments Body Spray	60-98
Avon RARE GOLD Eau de Parfum Spray	60-98
Avon RARE PEARLS Eau de Parfum Spray	60-98
Avon Simply Radiant Shimmering Body Spray	60-98
Avon Vintage Cologne Spray	60-98
Avon WILD COUNTRY After Shave	60-98
Avon WILD COUNTRY Cologne Spray	60-98
Avon Wild Country Outback After Shave Lotion	60-98
Avon Wild Country Outback Eau De Toilette Spray	60-98
Bath & Body Instant Anti-Bacterial Hand Gel-Freesia	60
Bay Rum After Shave Balm	30
Bold Liquid Laundry Detergent	1-5
Bravo Platinum Series Metered Air Freshener	15-25
Bulls Eye Clear Shellac	55
Cascade Crystal Clear Plus Shine Shield Rinse Agent 8.45 fl oz	3-7
Cheer Liquid Laundry Detergent	1-5
Clorox Dual Action Toilet Bowl Cleaner 1 Pt. 9 Fl. Oz. (Chambered Bottle)	1-5
Clorox Spring Mist Disinfecting Spray-Floral Fresh 18 Oz. (aerosol)	60-80
Cutter All Family Insect Repellent 2 Aerosol	35
Cutter All Family Insect Repellent Mosquito Repellent Pump Spray	39
Cutter Insect Repellent	17
Cutter Skinsations Insect Repellent 1, Aloe & Vitamin E, Clean Fresh Scent	50
Cutter Unscented Backwoods Insect Repellent, Water-Resistant Sport Formula, Aerosol	35
Cutter Unscented Backwoods Mosquito Wipes	29
Cutter Unscented Insect Repellent	37
Cutter Unscented Outdoorsman Insect Repellent II Pump Spray	44
Cutter Unscented Outdoorsman Insect Repellent, Water-Resistant Sport Formula, Aerosol	20

Incidental Alcohol Exposure

Alcohol-Containing Products

Product	*Alcohol %*
DAP Easy Bond Adhesive	1.0-5.0
Dawn Manual Pot and Pan Detergent	5-10
Dawn Manual Pot and Pan Detergent (Professional Line)	5-10
Deep Woods OFF!	50-60
Deep Woods Off! Pump Spray	30-40
Dermassage Dishwashing Hand Liquid - Regular	1-5
Downy Advanced w/Wrinkle Control Fabric Softener (Clean Breeze, Mountain Spring)	1-5
Downy Enhancer	1-5
Downy Enhancer (Invigorating Burst and Calming Mist)	1-5
Downy Premium Care	1-5
Dreft Liquid Laundry Detergent	1-5
Easy Off Heat Activated Microwave Wipes	5-10
Era Liquid Laundry Detergent	1-5
Fab Color Plus Ultra Power	1-5
Farnam Cologne & Deodorant for Pets	20
Febreze Air Effects 9.7 oz Blossoms and Breeze	3-7
Febreze Air Effects 9.7 oz Citrus and Light	3-7
Febreze Air Effects 9.7 oz Spring and Renewal	3-7
Febreze Concentrated Fabric Refresher	12-17
Febreze Fabric Refresher	1-5
Fire Up II Firestarter	<85
Gain Liquid Laundry Detergent	1-5
Giant Auto Dish Detergent 75 OZ BOX	1-5
Giant Pure Power Auto Dish Detergent Lemon 45 OZ BOX	1-5
Glade Fragrant Mist Country Garden	7-13
Glass Mates	4.0-6.0
Glass Mates-05/16/2000	4.0-6.0
HOUSE SAVER Pet Stain & Odor Remover	20
Invisible Shield Surface Protectant-04/11/2002	78
Ivory Snow Liquid Laundry Detergent	1-5
KimCare Instant Hand Sanitizer	60
Lady Speed Stick Clear Antiperspirant Deodorant Gel	15-20
Listerine Antiseptic Mouthwash	26.9
Listerine Cool Mint Antiseptic Mouthwash	23
Listerine Fresh Burst Antiseptic Mouthwash	23
Listermint Mouthwash	<10
Loctite Crafter's All Purpose Adhesive	3-5

Incidental Alcohol Exposure

Alcohol-Containing Products

Product	*Alcohol %*
Loctite Fabric Glue	3-5
Loctite Outdoor Fixture Adhesive	1-5
LOreal Pumping Curls for Curly Hair	41
Lysol Brand Antibacterial Hand Gel	63
Lysol Brand Disinfectant Spray, Antibacterial, Original Scent	79.0
Lysol Brand II Disinfectant Plus Fabric Refresher 12 oz	85
Lysol Brand II Disinfectant Spray-Country Scent (aerosol)	79
Lysol Brand Sanitizing Wipes-Citrus Scent	8-10
Lysol Brand Sanitizing Wipes-Spring Waterfall 52 oz	8-10
Lysol Brand Scrubbing Wipes-Orange Breeze Scent	8-12
Martin Weber Blue Label Fixatif Spray	60-70
Martin Weber Cleaning Solution	31
Mr Muscle Pot & Pan Detergent	3-7
Nair Hair Remover Kit, Cold Wax Strips Pretreatment Towelette	5-20
New-Skin Liquid Bandage	5
Nilodor Air Freshener-Floral	0.5-3.5
Nilodor Carpet Care Deodorizing Spot/Stain Remover	2-6
Nilodor Deodorizing Carpet Extractor	2-6
Nilodor Odor Neutralizer	0.5-3.5
Nilotex Carpet Care	2-6
Off Skintastic Insect Repellent for Kids	>90
Off! Deep Woods for Sportsmen Insect Repellent IV, Aerosol	50-60
Off! Deep Woods Insect Repellent V Spray, Unscented	50-60
Off! Skintastic IV	90-95
Old English Furniture Wipes	4-8
Oust Air Sanitizer, Outdoor Scent	60-70
Oust Bathroom Citrus Scent Fan .40 oz.	40-60
Oust Bathroom Outdoor Scent Fan	40-60
Palmolive Original Hand Dishwashing Liquid	4.3
Paul Mitchell Freeze & Shine Super Spray	>60
Paul Mitchell Freeze & Shine Super Spray (New)	<60
Paul Mitchell Soft Sculpting Spray Gel	<20
Pine Power Disinfectant Cleaner	<5.0
Purell Instant Hand Sanitizer	62
Purell Instant Hand Sanitizer Dry Hands Formula	62
Purell Instant Hand Sanitizer Packets	62
Purell Instant Hand Sanitizer with Aloe, Moisturizers & Vitamin E	62
Purell Instant Hand Sanitizer, Original	62

Incidental Alcohol Exposure

Alcohol-Containing Products

Product	*Alcohol %*
Purell Kids Own Berry Blast	62
Radio Shack 951 Low Residue Soldering Paste Flux	73
Radio Shack Cleaner/Degreaser	27
Radio Shack Professional Tape Head Cleaner	15-20
Rain X Marine Windshield Treatment	70-95
Rain X The Invisible Windshield Wiper	86
Rain-X Anti-Fog	70-99
Rain-X Windshield Wax	70-95
Repel Hunters' Insect Repellent with Earth Scent, 55 Percent DEET	<45
Repel Insect Repellent Family Formula Spray Pump, 23 Percent DEET	44
Repel Insect Repellent Scented Family Formula Aerosol, 23 Percent DEET	48.3
Repel Insect Repellent Sportsmen Formula Spray Pump, 25 Percent DEET	55
Repel Insect Repellent Sportsmen Max Formula, 40 Percent DEET	43.7
Repel Lemon Eucalyptus Insect Repellent Lotion	<10
Repel Lemon Eucalyptus Insect Repellent Spray Lotion	<10
Soft Soap Hand Sanitizer - Gel	60-65
Spic and Span 10X Concentrate Disinfecting All Purpose Spray	12-25
Spic and Span Floor and Multi Surface Cleaner	0-5
Spray N Wash Laundry Stain Remover	2-3
Static Guard	70-72
Survivor Lemon Eucalyptus Insect Repellent Lotion	<10
TEN O SIX Medicated Deep Pore Cleanser	<15
Time Mist Air Freshener W/Odor Counteractant	15-25
Ultra Downy Liquid Fabric Softener	1-5
Valspar One & Only Interior/Exterior Multi Purpose Flat Black Finish	5-10
Valspar One & Only Multi Purpose Gloss Enamel, Almond	5-10
Valspar One & Only Multi Purpose Gray Metal Primer	5-10
Viadent Advanced Care Rinse	5-10
Wet Ones Antibacterial Moist Towelettes, Citrus	9.6
Wet Ones Antibacterial Moist Towelettes, Travel Pack, Citrus	9.6
Wet Ones Antibacterial Portable Washcloths, Ultra	0-9.6
Wet Ones Kids Antibacterial Wipes, Wild Watermelon & Ballistic Berry	0-9.6
Wet Ones Moist Towelettes with Aloe, Travel Pac	0-10.5
Wet Ones Moist Towelettes with Vitamin E & Aloe	0-10.5
Wet Ones Portable Washcloths with Vitamin E & Aloe, Ultra	0-10.5
Wet Ones Ultra Portable Antibacterial Wash Cloths	9.6
Wet Ones, Antibacterial Moist Towelettes, Thick Cloths	9.6
Zep Tile and Terrazzo Cleaner	5-15

Incidental Alcohol Exposure

Alcohol Content of Over-the-Counter Medications

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Ambenyl	cough suppressant	Forest	5
Ambenyl-D	expectorant, nasal decongestant, cough suppressant	Forest	9.5
Anesol	oral antiseptic, anesthetic	Whitehall	70
AsbronG Elixir	anti-asthmatic	Sandoz	15
Bayer children's Cough Syrup	cough suppressant, nasal decongestant	Glenbrook	5
Benadryl Decongestant Elixir	antihistamine	Parke-Davis	5
Benadryl Elixir	antihistamine	Parke-Davis	14
Benylin Cough Syrup	cough suppressant	Parke-Davis	5
Benylin DM	cough suppressant	Parke-Davis	5
Bronkolixir	bronchodilator, decongestant	Winthrop	19
Cepacol/Cepacol Mint	mouthwash, gargle	Lakeside	14.5
Ce-Vi-Sol	vitamin C drops (infant)	Mead-Johnson	5
Cheracol D	cough suppressant, decongestant	Upjohn	4.75
Cheracol Plus	cough suppressant, decongestant	Upjohn	8
Chlor-Trimeton Allergy Syrup	antihistamine	Schering	7
Choedyl Elixir	bronchodilator	Parke-Davis	20
Colace Syrup	laxative	Mead-Johnson	1
Colgate Mouthwash	mouthwash/gargle	Colgate-Palmolive	15.3
CONTAC Nighttime	antihistamine, analgesic, cough suppressant, decongestant	SmithKline	25
Dilaudid Cough Syrup	cough suppressant, analgesic	Knoll	5
Dimetane Elixir	antihistamine	A. H. Robins	3
Dimetane Decongestant Elixir	antihistamine, decongestant	A. H. Robins	2.3
Dimetapp Elixir	decongestant, antihistamine	A. H. Robins	2.3
Diural Oral Suspension	diuretic, antihypertensive	Merck Sharp & Dohme	0.5
Donnatal Elixir	anti-spasmodic	A. H. Robins	23
Elixophyllin-Kl Elixir	anti-asthmatic	Forest	10
Feosol Elixir	iron supplement	SmithKline	5
Fergon Elixir	iron supplement	Winthrop	7
Geriplex-FS	vitamins (geriatric)	Parke-Davis	18
Geritol Liquid	vitamins	Beecham	12
Geritonic Liquid	vitamins	Geriatric	20
Gevrabon	vitamins	Lederle	18
Hycotuss	expectorant	DuPont	10
I.L.XB12 Elixir	iron supplement	Kenwood	8
Iberet Liquid	vitamins	Abbott	1

Incidental Alcohol Exposure

Alcohol Content of Over-the-Counter Medications

Item	*Use*	*Manufacturer*	*Alcohol %*
Imodium A-D	anti-diarrheal	McNeil	5.25
Incremin	vitamins	Lederle	0.75
Indocin Oral Suspension	analgesic	Merck Sharp & Dohme	1
Kaochlor S-F	potassium supplement	Adria	5
Kaon-CL 20%	potassium/chloride supplement	Adria	5
Kaon Elixir	potassium supplement	Adria	5
Kay Ciel Oral Solution	potassium supplement	Forest	4
Klorvess 10% Liquid	potassium/chloride supplement	Sandoz	0.75
Lanoxin Elixir Pediatric	cardiac medication	Burrougfhs Wellcome	10
Lasix Oral Solution	diuretic	Hoechst-roussel	11.5
Listerine Antiseptic	mouthwash/gargle	Warner-Lambert	26.9
Lomotil Liquid	anti-diarrheal	G. D. Searle & Co.	15
Lufyllin Elixir	bronchodilator	Wallace	20
Marax-DF Syrup	bronchodilator	Roerig	5
May-Vita Elixir	vitamins	Mayrand, Inc.	13
Mediatric Liquid	estrogen replacement	Wyeth-Ayerst	15
Mellaril Oral Solution	antipsychotic	Sandoz	3-4.2
Mestinon Syrup	treatment of myasthenia ravis	Roche	5
Naldecon DX Pediatric Drops	decongestant	Bristol	0.6
Nicotinex	niacin supplement	Fleming & Co.	14
Niferex Elixir	iron supplement	Center Labs	10
Novahistine Elixir	antihistamine, decongestant	Lakeside	5
Novahistine Expectorant	cough suppressant, decongestant, expectorant	Lakeside	7.5
Nucofed Expectorant	cough suppressant, decongestant, expectorant	Beecham	12.5
Nucofed Pediaric Expectorant	cough suppressant, expectorant, decongestant	Beecham	6
Nu-Iron Elixir	iron supplements	Mayrand, Inc.	10
Nystex Oral Suspension	antifungal antibiotic	Savage	1
Organidin Elixir	expectorant	Wallace	21.75
PBZ Elixir	antihistamine	Geigy	12
Pamelor Oral Solution	anti-depressant	Sandoz	3-5
Peri Colace Syrup	laxative	Mead-Johnson	10
Permitil Oral Concentrate	anti-psychotic	Schering	1
Phenergan Syrup Plain	antihistamine	Wyeth-Ayerst	7
Phenergan Syrup Fortis	antihistamine	Wyeth-Ayerst	1.5
Phenobarbital Elixir	sedative	Rosane	13.5
Polaramine Syrup	antihistamine	Schering	6

Incidental Alcohol Exposure

Alcohol Content of Over-the-Counter Medications

Item	*Use*	*Manufacturer*	*Alcohol %*
Poly-Histine Elixir	cough suppressant	Bock	4
Prolixin Elixir	anti-psychotic	Princeton	14
Quelidrine Syrup	cough suppressant	Abbott	2
Robitussin	expectorant	A. H. Robins	3.5
Robitussin A-C	cough suppressant, expectorant	A. H. Robins	3.5
Robitussin CF	cough suppressant, decongestant, expectorant	A.H. Robins	3.5
Robitussin DAC	expectorant, decongestant, cough suppressant	A. H. Robins	1.9
Robitussin Night Relief	analgesic, cough suppressant, decongestant	A. H. Robbins	25
Robitussin PE	decongestant, expectorant	A. H. Robbins	1.4
Sandimmune	immunosuppressant	Sandoz	12.5
Scot-Tussin Sugar-Free Expectorant	expectorant	Scott-Tussin	3.5
Sominex Liquid	sleep aid	Beecham	10
Sudafed Cough Syrup	decongestant	Burroughs Wellcome	2.4
Tacaryl Syrup	antihistamine	Westwood	7.37
Tagamet Liquid	ulcer medication	Smith Kline & French	2.8
Tavist Syrup	antihistamine	Sandoz	5.5
Theo-Organidin Elixir	bronchodilator, expectorant	Wallace	15
Triaminic Expectorant	expectorant, decongestant	Sandoz	5.5
Tussar-2	cough suppressant	Rorer	5
Tussar SF	cough suppressant	Rorer	12
Tussend	cough suppressant	Lakeside	5
Tussend Expectorant	cough suppressant, decongestant, expectorant	Lakeside	12.5
Tylenol Adult Liquid Pain Reliever	analgesic	McNeil	7
Tylenol Cold Medication Liquid	analgesic, decongestant, cough suppressant, antihistamine	McNeil	7
Tylenol with Codeine Elixir	analgesic	McNeil	7
Vicks Daycare Liquid	decongestant, analgesic, expectorant, cough suppressant	Richardson-Vicks	10
Vicks Formula 44	cough suppressant, antihistamine	Richardson-Vicks	10
Vicks Formula 44D	cough suppressant, decongestant	Richardson-Vicks	10
Vicks Formula 44M	cough suppressant, decongestant, analgesic	Richardson-Vicks	20
Vicks Nyquil	decongestant, cough suppressant, antihistamine, analgesic	Richardson-Vicks	25

Incidental Alcohol Exposure

Alcohol Content of Over-the-Counter Medications

Please note: Some prescription nasal sprays used for allergic rhinitis and some other forms of nasal/sinus congestion contain alcohol. Alcohol-containing nasal sprays that should be avoided by recovering persons, especially those taking Antabuse, include Flonase and Nasonex nasal sprays. The majority of mouthwashes contain alcohol also. These should all be avoided.

5% Alcohol (10-Proof)

Diphenhydramine Elixir

Benylin Cough Syrup

Cheracol-D Cough Syrup (guaifenesin/dextromethorphan)

Dihstine DH Elixir
(chlorpheniramine/pseudoephedrine/codeine)

Dilaudid Cough Syrup (hydromorphone)

Dramamine Liquid (dimenhydrinate)

Feosol (iron) Elixir

Imodium A-D (loperamide)

Kaon Liquid (potassium)

Kay Ciel Liquid (potassium)

Guiatuss AC Syrup (guaifenesin/codeine)

Phenergan VC Syrup (promethazine/phenylephrine)

Tussend Syrup
(guaifenesin/chlorpheniramine/pseudoephedrine/hydrocodone)

Tylenol Extra Strength Liquid

Tylenol with Codeine Elixir

Vicks 44 D (dextromethorphan/pseudoephedrine)

Vicks 44 E (guaifenesin/dextromethorphan)

10% Alcohol (20-Proof)

Excedrin PM Liquid
(acetaminophen/diphenhydramine)

Geritol Tonic Liquid (multivitamin)

Hycotuss Expectorant Syrup
(hydrocodone/guaifenesin)

Niferex Elixir (iron)

Nucofed Expectorant Syrup
(guaifenesin/pseudoephedrine/codeine)

Nu-Iron Elixir (iron)

Vicks Nyquil
(doxylamine/pseudoephedrine/dextromethorphan/acetaminophen)

Vicks Formula 44M
(chlorpheniramine/pseudoephedrine/dextromethorphan/acetaminophen)

15% Alcohol (30-Proof)

Cepacol Mouthwash

Gerivite Elixir (multivitamin)

Lomotil Liquid (diphenoxylate/atropine)

20% Alcohol (40-Proof)

Gevrabon Liquid (vitamins)

Listerine Mouthwash (flavored)

Lufyllin Elixir (theophylline)

Theophylline Elixir

25% Alcohol (50-Proof)

Listerine Mouthwash (regular)

N'ice Throat Spray

The Medication Guide
Version 1.6 - Sept 2013

This document was produced by Earley Consultancy, LLC
This product is to be used as a guide and not a definitive source for medical information. Please consult with your physician for a definitive medical opinion regarding medications or alcohol exposure.

For more information or consultation go to: www.paulearley.net

Earley Consultancy, L.L.C.
Addiction Training and Consultation

ISMA
INDIANA STATE MEDICAL ASSOCIATION

UNKOWN ESTABLISHMENT DATE

INITIATING THE PROCESS

Phone call or email

EXCLUSION CRITERIA

Case by case

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: Spectrum
Frequency: For alcohol, Soberlink with an addition of one UA per month; for other substances, typically 26 first year, then decreases to 12

REQUIRED MEETINGS

Varies in frequency based on assessment. Typically includes weekly 12 Step meetings and caduceus meetings

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

First year: Every six weeks in person
Second year: Every 7-9 weeks in person
Years 3-5: Require four contacts per year, two in person, two self assessments

CHEMICAL RELAPSES

Level system, 3-4 relapses in a year will likely cause a report to the board

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

No formal system for addressing this

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary (may not practice)
Buprenorphine: Case by case, but typically no. Must be approved by two Addictionologists
Medical Marijuana: N/A
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D.
Physicians – D.O.
Families of physicians (direction/guidance only)
Medical students
Residents

LENGTH OF MONITORING

Case by case: Mild SUD is typically 6 months to 1 year, moderate to severe SUD is 5 years

APPROXIMATE FEES

$20-$1,100 depending on profession

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Monthly letter to Board

STAFF

Candace Backer, LCSW, LCAC, Program Coordinator

1 LCSW Case Manager
1 Medical Consultant

FUNDING SOURCES

Medical Association
Private Contributions
Participant Fees

OF ACTIVE PARTICIPANTS

180
90%-95% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

80% completion rate

NO ADDITIONAL INFORMATION AVAILABLE

SINCE
1993

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

None

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Assessment done within PHP

TESTING

Agency: RecoveryTrek
Frequency: 2-3 times per week for the first 3 months, then move to about 48/year

REQUIRED MEETINGS

Caduceus groups once per week for first 3 months,
No 12 step participation required

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Typically monthly meetings with PHS staff member, 2-3 meetings per year can be with a PHS non-physician, the other must be with a physician

CHEMICAL RELAPSES

Case by case, required to report anything positive to the Medical Board

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

No level system, Medical Board has precluded them from using FSMB

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with assessment)
Opioids: Only when medically necessary (may be able to practice)
Buprenorphine: Yes (taper not required)
Medical Marijuana: No
Recreational Marijuana: N/A, see above

PROFESSIONS SERVED

Physicians – M.D.
Physicians – D.O.
Residents
Medical Students

LENGTH OF MONITORING

5 years for SUD, if there's no concern about mandating reporting issues, then 3 years

APPROXIMATE FEES

Free

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Yes, if compliant

STAFF

Bara Litman-Pike,
Psy.D, Executive Director
Steve A. Adelman, MD, Director

1 General Counsel
1 Physician Evaluation Director
2 Associate Directors
1 Monitoring Associate
1 Outreach & Funding Coordinator
2 Client Services Coordinators
1 Monitoring Services Coordinator
1 PHS Assistant

FUNDING SOURCES

Professional organizations
Malpractice insurance companies
Professional boards

OF ACTIVE PARTICIPANTS

140
75% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

No formal tracking system, but seems to correlate with national standards

Table of Contents

PHYSICIAN HEALTH SERVICES

A Massachusetts Medical Society corporation
www.physicianhealth.org

DATE: _____ **PHS ID #:**_____

PLEASE PRINT OR TYPE CLEARLY

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ____ Suffix: _____

Sex: _____ Date of Birth: ____/____/_____ Degree:_____

Marital Status:

☐ *MARRIED* ☐ *SINGLE* ☐ *DIVORCED* ☐ *WIDOWED* ☐ *CIVIL UNION*

Spouse/Significant Other (optional): Last Name: _____ First Name: _____

Primary Specialty: _____ Second Specialty: _____

☐ Resident - Post Graduate Year 1 2 3 4 5 6 ☐ Medical Student 1 2 3 4

HOME ADDRESS:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax_____Email: _____

WORK ADDRESS

ORGANIZATION:_____- Title:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Fax: _____

OTHER ADDRESS:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Fax: _____

PREFERRED PLACE OF MAIL: ☐ *HOME* ☐ *WORK* ☐ *OTHER:* _____

PREFERRED PLACE OF CONTACT: ☐ *HOME* ☐ *WORK* ☐ *OTHER:* _____

ORGANIZATIONS/HOSPITAL AFFILIATIONS: _____

CURRENT MALPRACTICE CARRIER: _____

Name: _____

Address _____

City: _____ State: _____ Zip: _____

LICENSING INFORMATION:

Massachusetts #: _____ Status: _____

Other State(s) #: _____ Status: _____

REFERRAL SOURCE: ***RELATIONSHIP (CIRCLE ONE):***

self colleague family member: _____ spouse attorney

organization attorney licensing board therapist primary care physician residency program

medical school patient organization administration/leadership organization non-physician staff

organization physician assistance committee malpractice carrier: _____

other state physician health program:_____ other: _____

NAME:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Fax: _____

THERAPIST: ***NOT APPLICABLE:*** ☐

Last Name: _____ First Name: _____ Suffix: _____

Degree: _____ Title: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PRIMARY CARE PHYSICIAN:

Last Name: _____ First Name: _____ Suffix: _____

Degree: _____ Title: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

ATTORNEY: ***NOT APPLICABLE*** ☐

Last Name: _____ First Name: _____ Suffix: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

OTHER INFORMATION:

Inpatient Treatment: ☐ Not Applicable

☐ Applicable Date Entering: _____

Facility: _____

Therapy Frequency: _____

Support Group Meetings: _____

(name of groups & locations) _____

Support Group Frequency: _____

PHS RELEASE OF INFORMATION PROCEDURE
860 WINTER STREET,
WALTHAM, MA 02451

PHS PHONE (781) 434-7404 PHS FAX (781) 893-5321

Attached is a Physician Health Services (PHS) release of information form. You may be requesting a letter to document your participation in the program for credentialing purposes, or you may want to authorize PHS to communicate with a third party such as your employer or attorney. This form is also used at the request of PHS to gather information from individuals for the purpose of an assessment.

PLEASE NOTE:

1. **TO BE CONSIDERED COMPLETE, PLEASE FILL OUT ALL SECTIONS OF THE FORM.**

2. **PROVIDE A WRITTEN REQUEST AND SPECIFY THE INFORMATION TO BE RELEASED.**
   Requests for disclosure of information regarding your participation with the program must be in writing.

3. **PROVIDE PHS A COPY OF THE REQUEST FOR INFORMATION FROM A THIRD PARTY.**
   If you have received a written request for information from a third party, it is important that you provide PHS with a copy of the request along with your release reflecting the specific information being sought. For example, some third parties may be satisfied with a simple verification that a physician is in a monitoring program, whereas others might require a more detailed account of the monitoring process, the physician's compliance with an agreement, or ongoing quarterly reports. It is critical that we understand the extent of the inquiry so that we will know what information to release.

4. **LEGAL COUNSEL**
   We encourage you to rely on your personal legal counsel in completing this form.

5. **PROVIDE PHS A MONTH TO RESPOND OR SPECIFY A DEADLINE.**
   PHS urges you to provide all written requests for release of information one month prior to the time it is required to be released, specifying the date the information is to be provided.

6. **PLEASE CALL PHS AT (781) 434-7404. IF YOU HAVE QUESTIONS OR NEED ASSISTANCE.**

7. **THIS FORM MAY BE FAXED TO PHS AT (781) 893-5321 OR MAILED TO PHS AT 860 WINTER STREET, WALTHAM, MA 02451**

Thank you.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Physician Health Services, Inc
860 Winter St.,Waltham, MA 02451
PHONE: (781) 434-7404 FAX: (781) 893-5321

TO DISCLOSE TO AND COMMUNICATE WITH:

Name _____

Organization _____

Address _____

_____

Phone _____***Email***_____

RELATIONSHIP (CIRCLE ONE):

attorney licensing board colleague family member: _____ spouse patient
professional coach therapist/psychiatrist evaluator/treatment center primary care physician probation officer
medical provider (other than PCP) organization: attorney organization: administration/leadership organization: physician staff
organization: non-physician staff organization: physician assistance committee medical school residency program
other state physician health program malpractice carrier: _____ other: _____

THE FOLLOWING INFORMATION *(Nature of information, as limited as possible)*:

_____
_____
_____

Examples:
- Description of PHS participation
- compliance letter
- copy of PHS recommendations

THE PURPOSE OF THE DISCLOSURE AUTHORIZED HEREIN IS TO *(Purpose of the disclosure, as limited as possible)*:

_____
_____
_____

Examples:
- Provide employer or credentialer Status or update of compliance
- Address monitoring recommendations
- Address PHS assessment

EXPIRATION *(You must specify a date, event, or condition upon which this consent expires)*:

_____
_____

Examples:
- Upon termination of my involvements with PHS
- One year from below date

I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

FOR DRUG AND ALCOHOL RELATED MATTERS:
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date: _____ _____
Signature

_____
Printed Name

~Information released by Physician Health Services may be limited in accordance with Massachusetts peer review law.~

<u>Request Form for Time Off the Random Call Schedule</u>

Name ______________________________________ ID # _______________

Associate Director ______________________________________

Today's Date____________________________

Dates I will be unavailable for testing: _______________________ to _______________________

I am providing at least 2 weeks' notice: YES_____ NO_____

If no, please explain ____

____

Reason for unavailability and location: (e.g.: vacation, CME course)

____

____

I will ***not*** be practicing medicine during this time. YES_____ NO_____

If you ***will*** be practicing medicine, please explain why you need to be excused from testing.

____

____

If vacation is more than 2 weeks (16 days) I understand the following apply. YES_____

In the event I am traveling or otherwise unavailable for testing for more than a two-week period (>16 days), I understand I need to the following:

(1) provide my PHS associate director with the scheduled dates of my leaving and return

(2) be drug tested upon my return

(3) not practice medicine until the test result is received by PHS and is negative

(4) submit to two drug tests per week for the first two weeks following my return.

I also understand that unavailability for testing of two weeks or more (>16 days) is subject to the approval of the director of PHS. Future letters of compliance written on my behalf may exclude such periods of time in which my compliance was not documented. The length of this contract may be extended based on the length of time of any extended absences in monitoring.

Is time off within the first 12 weeks of testing? YES______ NO______

If time off is within the first 12 weeks of testing, I understand I cannot miss any weekly random tests and may need to set up testing with PHS during travel.

I have received approval from my Associate Director. YES_____ NO_____

- -

(PHS only) MSA confirmed AD approval. ____________________(date)

MSA has sought DIRECTOR review for time off > 16 days. YES_____ NO_____

Urine Drug Screen (UDS) Collection Site List for *Physician Health Services*

February 28, 2019

www.questdiagnostics.com or www.employersolutions.com

Quest Sites Address	Address 2	City	State		Zip	Phone	Fax Number	UDS HOURS	Hours of Operation	Site	UDS & DOT
138 Haverhill Street	Doctors Park	**Andover**	MA	*	01810	978-475-7520	978-475-3455	**M-F 8:30 - 2:00**	M-F 6:00 - 3:00	PSC	**Yes**
221 Boston Road	Suite 1	**Billerica**	MA		01862	978-667-5212	978-439-0170	**M-F 8:30-12 & 1-3:30**	M-F 8:00 - 4:00 Closed for lunch 12:00 - 1:00	PSC	**Yes**
319 Longwood Avenue	First Fl, Sute 1	**Boston**	MA	*	02115	617-731-2240	617-732-1528	**M-F 9-12 & 1-4**	M-F 8:30-5:00 Closed for lunch 12:00 - 1:00	PSC	**Yes**
340 Wood Road	Suite 302	**Braintree**	MA		02184	781-849-7993	781-843-1195	**M-F 9-1:00 & 1:30-3:00**	M-F 8:00 - 4:00 Closed for lunch 1:00 - 1:30	PSC	**Yes**
210 Quincy Avenue		**Brockton**	MA		02302	508-586-5955	508-587-6998	**M-F 8-12 & 1-2**	M-F 7:30 - 3:00 Closed for lunch 12:00 - 1:00	PSC	**Yes**
1180 Beacon Street	Suite 1D	**Brookline**	MA	*	02446	617-232-5733	617-739-2941	**M-F 9-12:15 & 1:15 -4**	M-F 8:00 - 5:00 Closed for lunch 12:15-1:15	PSC	**Yes**
39 Village Square		**Chelmsford**	MA		01824	978-256-1268	978-256-9716	**M-F 9-12 & 1-3**	M-F 7:30 - 4 Closed for lunch 12-1	PSC	**Yes**
223 Chief Justice Highway	Lower Level 3	**Cohasset**	MA		02025	781-383-0180	781-383-9093	**M-F 9:00 - 4:00**	M-F 7:30 - 5:00	PSC	**Yes**
180-182 Endicott St	Next to Bed Bath & Beyond	**Danvers**	MA	*	01923	978-777-7879	978-777-7898	**M-F 9:00 - 3:00**	M-F 8:30 - 4:00	PSC	**Yes**
101 President Ave	1st Floor	**Fall River**	MA		02720	508-324-4105	508-646-3645	**M-F 9-12 & 12:30-3**	M-F 7:30 - 4:00 Closed for lunch 12 -12:30	PSC	**Yes**
350 Gifford St, Ste 15-17	Homeport	**Falmouth**	MA		02540	508-540-2642	508-540-2761	**M-F 9-12 & 1-2**	M-F 7-3:30 Closed for lunch 12 - 1	PSC	**Yes**
10 Commercial Street	Job Lot Plaza	**Foxboro**	MA		02035	508-698-1721	508-698-5299	**M-F 9:00 - 3:00**	M-F 7:00 - 4:00	PSC	**Yes**
61 Lincoln Street, Ste 308	**NO BLOOD COLLECTIONS!**	**Framingham**	MA		01702	508-370-7341	508-370-7471	**M-F 9:00 - 3:00**	M-W, F 8:00 - 5:00 Th 7:30 - 4:00	PSC	**Yes**
1421 Orleans Rd. Route 39	2nd Floor, Ste 102	**Harwich (East)**	MA	*	02645	508-432-7764	508-430-5453	**M-F 9:00 - 11:30**	M-F 6:30 - 7:00 Closed for lunch 12 - 1	PSC	**Yes**
51 Main Street, Ste 6	Main Street Medical Building	**Hyannis**	MA		02601	508-778-4100	508-778-4774	**M-F 10:00 - 3:00**	M-F 6:30 - 5:00	PSC	**Yes**
79 Erdman Way, Ste 100		**Leominster**	MA		01453	978-466-9009	978-466-9999	**M-F 8:30-11:30 & 1-3:30**	M-F 7:00 - 5:00 Closed for lunch 12:30 - 1	PSC	**Yes**
700 Rogers Street		**Lowell**	MA		01854	978-458-7980	978-458-7981	**MTThF 9-1 & 2-4 Wed 9-11:30**	MTF 8-5; W 8-12; Th 8-6 Closed for lunch 1-2	PSC	**Yes**
1 Branch Street		**Methuen**	MA		01844	978-688-4745	978-681-5036	**M-F 9-12 & 1-3**	M-F 8:00 - 4:00 Closed for lunch noon - 1:00	PSC	**Yes**
237 State Road		**N. Dartmouth**	MA		02747	508-999-9989	508-999-9959	**M-F 8:00 - 3:00**	M-F 7:30 - 4:00	PSC	**Yes**
335 Morse Street	First Floor	**Norwood**	MA		02062	781-769-5128	781-769-8853	**M-F 9:00 - 3:00**	M-F 7:00 - 4:00	PSC	**Yes**

UDS = Urine Drug Screens DOT = Department of Transportation (NIDA)

Quest Sites Address	Address 2	City	State	Zip	Phone	Fax Number	UDS HOURS	Hours of Operation	Site	UDS & DOT
229 Cranberry Highway		**Orleans**	MA	02653	508-255-2010	508-240-0464	**M-F 9-12 & 1-2**	M-F 6:30 - 2:30 Closed for lunch noon - 1:00	PSC	**Yes**
42 Summer Street		**Pittsfield**	MA	01201	413-499-8718	413-499-8754	**M-W 9-12:30 & 1-3:30 ThF 9-12:30 & 1-2:30**	M-W 8:30-12:30 & 1-4 Th-F 7:30-12:30 & 1-3	PSC	**Yes**
57 Long Pond Rd		**Plymouth**	MA	02360	508-747-1570	508-747-1579	**MTThF 8-10 & 11:30-1:30 Wed 8-10**	MTThF 6-11 & 11:30-2:30 Wed 6-11	PSC	**yes**
500 Congress Street, Ste 1E	Crown Colony Medical Center	**Quincy**	MA	02169	617-773-0080	617-773-9068	**M-F 9 - 3**	M-F 8:00 - 4:00	PSC	**Yes**
851 Main Street	Ste 17, 2nd Floor Nevin Bldg	**S Weymouth**	MA	02190	781-335-4208	781-331-5240	**M-F 9-12 & 1-3**	M-F 7:30 - 4:00 Closed for lunch noon -1	PSC	**Yes**
1284 St. James Ave		**Springfield**	MA	01104	413-755-1711	413-755-1717	**M-F 9:00 - 3:30**	M-F 8:00 - 4:30	PSC	**Yes**
106 Main Street	Suite 4	**Wareham**	MA	02571	508-295-0477	508-295-8098	**M-F 9-12 & 1-2**	M-F 7:30 - 3:00 Closed for lunch 12 - 1	PSC	**Yes**
253 Pleasant Lake Ave	Rte 124; Suite A, Rear Lower Level	**West Harwich**	MA	02645	508-430-1592	508-430-1593	**M-F 9-12 & 1-2**	M-F 7:00 - 3:30 Closed for lunch 12 - 1	PSC	**Yes**
100 MLK Jr. Blvd	Lower Level	**Worcester**	MA *	01608	508-754-0178	508-754-0736	**M-F 9:00 - 3:30**	M-F 8:00 - 4:30	PSC	**Yes**
100 Hazard Ave, Ste 203		**Enfield**	**CT**	06082	860-698-4839	860-749-1498	**M-F 9:00 - 3:30**	M-F 7:30 - 4:30	PSC	**Yes**
280 Pleasant Street		**Concord**	**NH**	03301	603-229-0684	603-226-0487	**M-F 9:00 - 2:00**	M-F 7:30 - 3:00	PSC	**Yes**
195 MacGregor Street	Center Entrance	**Manchester**	**NH**	03102	603-625-2864	603-625-5469	**M-F 9-12 & 1-2**	M-F 6:00 - 3:00 Closed for lunch noon -1	PSC	**Yes**
300 Main Street	Suite 301B	**Nashua**	**NH**	03060	603-578-0321	603-578-0298	**M-F 8-12 & 1-2**	M-F 7:00 - 3:00 Closed for Lunch 12-1	PSC	**Yes**
200 Griffin Rd, Unit 12		**Portsmouth**	**NH**	03801	603-431-1325	603-431-1365	**M-F 9-12 & 1-2**	M-F 7:00 - 3:00 Closed for lunch noon - 1	PSC	**Yes**
8 Stiles Rd	Suite 111	**Salem**	**NH**	03079	603-890-6053	603-870-5496	**M-F 8:00 - 3:00**	M-F 6:30 - 5:00 Sat 7:00-11:00 AM	PSC	**Yes**
1 Randall Square		**Providence**	**RI**	02904	401-456-0545	401-456-0588	**M-F 9-12 & 12:30-4**	M-F 7:00 - 4:30 Closed for lunch noon-12:30	PSC	**Yes**

UDS = Urine Drug Screens DOT = Department of Transportation (NIDA)

Quest Sites Address	Address 2	City	State	Zip	Phone	Fax Number	UDS HOURS	Hours of Operation	Site	UDS & DOT
The following collection sites are available with EXTENDED HOURS										
These 3rd Party Drug Collection Sites are available for a minimal additional collection fee which will appear in your RecoveryTrek billing.										
A.F.C. Urgent Care-Burlington 90 Middlesex Turnpike		**Burlington**	MA *	01803	781-270-4700	781-270-4701	**M-Su 8:00-8:00**	M-Su 8:00-8:00	Preferred	**Yes**
A.F.C. Urgent Care-Waltham 1030 Main Street		**Waltham**	MA *	02451	781-894-6900	781-894-6901	**M-Su 8:00-8:00**	M-Su 8:00-8:00	Preferred	**Yes**
EMSI - Woburn 800 W. Cummings Park	Suite 5225	**Woburn**	**MA**	01801	781-376-1806	781-376-4165	**M-F 9:00-4:00**	M-F 9:00-4:00	Preferred	**Yes**
This 3rd Party Drug Collection Site is available for an additional $20 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
New England Drug Testing 490 Shrewsbury St	**NO BLOOD COLLECTIONS!**	**Worcester ***	MA *	01604	508-762-1146	508-762-1248	**M-F 8:30-5:00**	M-F 8:30-4:45	Preferred	**Yes**
This 3rd Party Drug Collection Sites is available for an additional $25 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
Family Care Medical Center 1515 Allen Street	**NO BLOOD COLLECTIONS!**	**Springfield**	MA	01118	413-783-9114	413-782-0960	**M-F 9:00-9:00** Sa-Su 9:00-5:00	M-F 9:00-9:00 Sa-Su 9:00-5:00		**Yes**
This 3rd Party Drug Collection Sites is available for an additional (approximately) $25 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
Arcpoint Labs		**New Bedford**	MA	02746	508- 990-1900		**M-Su 8:00-8:00**	M-F 8:00-8:00 Sa-Su 8:00-5:00		**Yes**
This 3rd Party Drug Collection Site is available for an additional $28 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
South Coast Occ Health 101 Page Street		**New Bedford**	MA *	02740	508-973-5469	508-973-5472	**M-F 8:00-11:30 & 12:30-3**			**Yes**
This 3rd Party Drug Collection Site is available for an additional $30 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
Pham Medical Associates 1996 Centre Street		**West Roxbury**	MA	02132	617-469-0470		**T-W-F 8AM-5PM** **M&Th 9AM-5PM**			
Arcpoint Labs 325 Turnpike Rd, #105		**Southborough**	MA	01772	508-281-0501	508-281-0503	**M-F 8:30-5:30**			**Yes**
These 3rd Party Drug Collection Sites are available for an additional $35 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
AEIOU 170 University Drive		**Amherst**	MA	01002	413-461-3530	413-461-3532	**8AM to 8PM**	M-F 8:00-8:00PM Sa-Su11:00AM-5:00PM		**Yes**
AEIOU 489 Bernardston Road		**Greenfield**	MA	01301	413-773-1394	413-773-1396	**8AM to 8PM**	M-F 8:00-8:00PM Sa-Su11:00AM-5:00PM		**Yes**
These 3rd Party Drug Collection Sites are available for an additional $40 collection fee which is PAYABLE AT THE TIME OF SERVICE.										
A.F.C. Urgent Care 129 Turnpike St.		**North Andover**	MA	01945	978-470-0800	978-208-0332	**M-F 8:00-8:00**	M-F 8:00-8:00		**Yes**
A.F.C. Urgent Care 119 Coggeshall St.		**New Bedford**	MA	02746	508-990-1900	508-990-1929	**M-F 8:00-8:00** **Sa-Su 8:00-5:00**	M-F 8:00-8:00 Sa-Su 8:00-5:00		**Yes**

Please note this listing was last updated on 2/28/19. Changes to site locations and hours could have occurred. For the most up-to-date information, please contact the site or PHS directly.

K:\PHMS\Quest\Quest Sites Lists- 2019-02-28_PHS UDS List with headers

UDS = Urine Drug Screens DOT = Department of Transportation (NIDA)

URINE ABSTINENCE TESTING AND INCIDENTAL ALCOHOL EXPOSURE

Recent advances in the science of alcohol detection in urine have greatly increased the ability to detect even trace amounts of alcohol consumption. In addition, these tests are capable of detecting alcohol ingestion for significantly longer periods of time after a drinking episode. Because these tests are sensitive, in rare circumstances, exposure to non-beverage alcohol sources can result in detectible levels of alcohol (or its breakdown products).

It is ***your*** responsibility to limit your exposure to the products and substances, including those detailed below, that contain ethyl alcohol. It is your responsibility to read product labels, to know what is contained in the products you use and consume and to stop and inspect these products ***BEFORE*** you use them. ***Use of the products detailed below may result in a positive test which may be reported to the Board of Registration in Medicine and others named in your monitoring contract. When in doubt, don't use, consume or apply***.

Cough syrups and other liquid medications: It is important to avoid alcohol-containing cough/cold syrups, such as Nyquil®. Other cough syrup brands and numerous other liquid medications, rely upon ethyl alcohol as a solvent. Please be sure to read product labels carefully to determine if they contain ethyl alcohol (ethanol). Non-alcohol containing cough and cold remedies are readily available at most pharmacies and major retail stores.

Non-Alcoholic Beer and Wine: Although legally considered non-alcoholic, NA beers (e.g. O'Douls®, Sharps®) do contain a residual amount of alcohol that may result in a positive test result for alcohol, if consumed.

Food and Other Ingestible Products: There are numerous other consumable products that contain ethyl alcohol that could result in a positive test for alcohol. Flavoring extracts, such as vanilla or almond extract, and liquid herbal extracts (such as Ginko Biloba), could result in a positive screen for alcohol or its breakdown products. Communion wine, food cooked with wine, and flambé dishes (alcohol poured over a food and ignited such as cherries jubilee, baked Alaska) must be avoided. Read carefully the labels on any liquid herbal or homeopathic remedy as well.

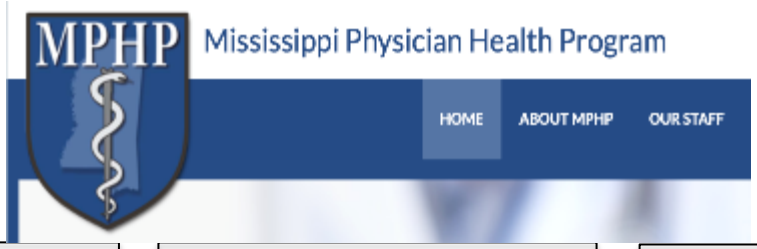
Mouthwash and Breath Strips: Most mouthwashes (Listermint®, Cepacol®, etc.) and other breath cleansing products contain ethyl alcohol. The use of mouthwashes containing ethyl alcohol can produce a positive test result. Non-alcohol mouthwashes are readily available and are an acceptable alternative. If you have questions about a particular product, bring it in to discuss with your associate director.

Hand sanitizers: Hand sanitizers (e.g. Purell®, Germex®, etc.) and other antiseptic gels and foams used to disinfect hands contain up to 70% ethyl alcohol. Excessive or repeated use of these products could result in a positive urine test

Hygiene Products: Aftershaves and colognes, hair sprays and mousse, astringents, insecticides (bug sprays such as Off®) and some body washes contain ethyl alcohol. While it is unlikely that limited use of these products would result in a positive test for alcohol (or its breakdown products) excessive, unnecessary or repeated use of these products could affect test results. Participants must use such products sparingly and avoid breathing the fumes to avoid reaching detection levels.

Solvents and Lacquers. Many solvents, lacquers and surface preparation products used in industry, construction, and the home, contain ethyl alcohol. Excessive inhalation of vapors can potentially cause a positive test result for alcohol. As with the products noted above, it is important to educate yourself as to the ingredients in the products you are using. There are alternatives to nearly any item containing ethyl alcohol. Frequency of use and duration of exposure to such products should be kept to a minimum. If you are in employment where contact with such products cannot be avoided, *please discuss this with your associate director*. Do not wait for a positive test result to do so.

Remember! When in doubt, don't use, consume or apply.



SINCE 1978

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

Case by case

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: Spectrum
Frequency: 30-50 times in first year, 15 in second and third, 6-10 in fourth year, increase to 15 in year 5

REQUIRED MEETINGS

Varies based on assessment

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Quarterly in person meetings at office during first year, then two times per year thereafter

CHEMICAL RELAPSES

Case by case; typically require reassessment, and asked to stop working

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Case by case basis

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: No
Buprenorphine: No
Medical Marijuana: N/A
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Medical students
Residents
Physician assistants
Podiatrists

LENGTH OF MONITORING

1 to 2 years for mild SUD, 5 years for moderate to severe SUD

APPROXIMATE FEES

$50-$200 depending on profession

SAFE HARBOR

Non-mandated: Yes, if compliant, quarterly reports with anonymous data
Mandated: Quarterly report that identifies physician

STAFF

Scott L. Hambleton, M.D., Medical Director
Kristi R. Plotner, LCSW, Executive Director
Kristin Wallace, LMSW, Clinical Director

FUNDING SOURCES

Private contributions
Participant fees
Licensing renewal fees

OF ACTIVE PARTICIPANTS

120
90% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

90% have no relapses

Table of Contents

Mississippi Physician Health Program

MPHP INTAKE FORM

(Please do not leave any section blank.)

Name: **Date:**

Date of Birth:

SS#:

Home Address:

Home phone number: **Cell phone number:**

Email:

Name, address, and phone number of spouse or significant other:

Name and phone number for emergency contact person at work:

Name and phone number for additional emergency contact person:

PRACTICE INFORMATION:

Specialty:

List ALL State(s) where license held: Primary: Other:

Status of MS license: Active Inactive Out of State Retired Unlicensed

Primary Medical (Other) School Attended: Grad Year:

Residency: Grad Year:

Residency: (other specialties) Grad Year:

Employer/Practice name, address and phone number:

Hospital Where You Have Staff Privileges:

Are you supervising, or in collaboration with, Nurse Practitioners? Yes or No

If yes, indicate number _____ and setting(s) _____

MSMA Member: Yes or No

PRIOR TREATMENT, THERAPY, EVALUATION, OR PSYCHIATRIC HOSPITALIZATION(S)

For each treatment, include: 1. Facility Name(s), 2. Dates of treatment, 3. Diagnosis, 4. Duration of treatment, and 5. Discharge status (e.g., AMA discharge, or appropriate discharge)

List all Psychiatric Diagnosis or Comorbidity (Dual Diagnosis):

Axis I:

Axis II:

List ALL substances abused:

Date of Sobriety:

HEALTH CARE PROVIDER INFORMATION:

(Include name, address and phone number for each.)

Primary Care Physician:

Psychiatrist (if applicable):

Therapist (if applicable):

Prescription Medications, Dose and Frequency:

REASON FOR MPHP CONTACT (WHY YOU ARE HERE)

(Please use additional sheet, if necessary.)

Participant Signature: _____

Mississippi Professionals Health Program
408 West Parkway Place – Ridgeland, MS 39157
(601) 420-0240 Fax (601) 707-3794

CURRENT MEDICATION FORM

Name:_____ Date: _____

Please provide all medications currently prescribed for you in the chart below and fax to MPHP. If any mood altering substances have been prescribed, please have your physician fax a copy of your prescription **IMMEDIATELY** to 601-707-3794. (Please refer to your contract if you have questions.)

Drug Name	Dosage	Frequency	Date Prescribed	Prescribing Physician	Prescribing Physician's Phone Number

Comments:

_____

_____

_____

_____

MS PHYSICIAN HEALTH PROGRAM
MONTHLY REPORT
(E-mail to kplotner@msphp.com)

Participant Name or Number: **Date:**

If you answer "Y" to any of the questions below, please indicate exactly what has changed. Return your form to MPHP NO LATER THAN THE 7th OF THE MONTH.

1) Are there any changes in your practice name/location/situation since last month? Y or N

2) Are there any changes in your licensure status for this state or any other state? Y or N

3) Are there any changes in your current health-care providers since last month? Y or N

4) Are there any changes in your medications since last month? Y or N

5) Are there any changes in your home address, your phone numbers or your e-mail addresses since last month? Y or N

MS PHYSICIAN HEALTH PROGRAM
QUARTERLY REPORT
(E-mail to sstanley@msphp.com)

Participant Name or Number:

Date: **DOB:** **SS# xxx-xx-** **Specialty:**

State(s) where license(s) held: **Primary:** **Other:**

Practice Name/Address/Phone (If more than one address, list each separately):

Staff Privileges - List Hospital Name(s)

Do you supervise Nurse Practitioners? Y N If yes, how many? Where?

Home Address/Phone/E-mail: (If you prefer to use P. O. Box, list physical address as well.)

Sobriety Date (if applicable): **Next MPHP Office Visit Date:**

Current Providers:
1. **Primary Care Physician:**
2. **Psychiatrist (if applicable):**
3. **Therapist (if applicable):**
4. **Workplace Monitor:**
5. **Medication Monitor:**
6. **Any changes in providers this month?**

Prescription Medications and Dosage (if you have more, please include in return e-mail)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Any changes MPHP needs to be aware of this month?

Additional Comments:

Mississippi Physician Health Program

Psychiatrist/Therapist Report
(Personal and Confidential)
Quarterly Progress Report

From: _____
Psychiatrist/Therapist Name (Printed)

March – June – September - December
(please circle one)

Re: _____
Physician Name (Printed)

Case Manager: Kristin A. Powell, LCSW
Clinical Case Manager
Ph: 601-420-0240 Ext. 105

MPHP has the above physician's consent to request reports from you on a periodic basis. **Your report is crucial to this person's contract compliance.** In order to facilitate the reporting process, we ask that you fill out the information below and **return it to Kristin A. Powell, LCSW via kpowell@msphp.com or fax number 601-499-1224**. Thank you.

Diagnosis:	
Treatment plan and number of visits this quarter:	
Current Medication:	
Compliance/Commitment:	
Fitness for Duty:	
Additional Comments:	

MPHP wishes to respect the Doctor/Patient relationship, however, we make program participants aware that their psychiatrist/therapist is asked to call us if: 1) a chemically dependent patient is in relapse; 2) there is a potential risk to the public; and/or 3) in the therapist's opinion, the participant is unable to practice with reasonable skill and safety.

Would you like for a representative of MPHP to contact you? Yes ☥☥ No ☥☥

If yes, please provide your phone number: _____

_____ _____
Psychiatrist/Therapist Signature Date

Mississippi Physician Health Program

WORKPLACE MONITOR REPORT
(Personal and Confidential)
Quarterly Progress Report

From: _____
Workplace Monitor

March – June – September - December
(circle one)

Re:_____
Physician Name (Printed)

MPHP contact: Kristi R. Plotner, LCSW
601-420-0240 ext 103

This form reflects your input as the above physician's Workplace Monitor. Please respond by checking the appropriate box regarding concerns in any of the following areas.

Information on this form is strictly confidential. Please be cognizant of this while it is in your possession. Please fill out and return this form quarterly to **Kristi R. Plotner, LCSW via email @ kplotner@msphp.com or Fax No. 601-707-3794**. You are welcome to contact MPHP at any time. Thank you for your cooperation.

	YES	NO
Irritability	☐	☐
Irresponsibility	☐	☐
Inability	☐	☐
Isolation	☐	☐
Incidentals	☐	☐

Comments: _____
_____
_____

How many times have you had personal contact in the last three months? _____

Would you like MPHP to contact you? Yes ☐ No ☐

_____ Date: _____
Workplace Monitor Signature

Phone: _____

Thank you,
Kristi R. Plotner, LCSW
Executive Director
kplotner@msphp.com
Private Fax No. 601-707-3794

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Washington Health Professional Services
Post Office Box 47864 • Olympia, Washington 98504-7872• whps@doh.wa.gov• Tel 360.236.2880• Fax 360.664.8588

Avoiding a Dilute Urine

Urine samples are called **Abnormal** if the creatinine is less than 20mg/dl and **Dilute** if, in addition to the low creatinine, the specific gravity is <1.0030 and > 1.0010. Both abnormal and dilute screens are of significance. These numbers are somewhat arbitrary but were chosen because most subjects must consume significant amounts of water to produce a specimen with a creatinine lower than 20 mg/dl. It has been noted that small muscle mass, being female, and exercise (when followed by increased water consumption) have been associated with lower urine creatinine levels. Urine dilution is of interest only because consuming large amounts of water in order to dilute urine with hopes of having negative urine is a common method to avoid detection. Dilution is also the method by which most of the OTC urine cleaners work. The problem with assuming that dilute urine is always due to attempted cheating is that many individuals drink large amounts of water for health reasons or simply to "be prepared" to provide a urine sample. Since dilute urines can be used to mask using, it is imperative to follow up on them. As a participant providing a urine sample, you can follow some simple guidelines to avoid providing dilute urine. These are:

- Avoid all diuretics—including caffeine—the day of the selection until AFTER the collection is done.
- Go to the collection site while the first morning urine is still in your bladder to use this as the specimen.
- If this is NOT possible then you should empty your bladder approximately 2 hours prior to your planned arrival at the collection site.
- During that time, you should NOT consume more than 24 oz of fluid and the fluid you do consume should be a substantial fluid—milk, smoothie, tomato juice—and/or you eat a protein high meal or snack—egg, cheese, meat.

By following these guidelines, you will help to avoid dilute and abnormal urines and ensure that the result of your test provides a valid indicator of your sobriety.

Thank you,

WHPS Case Management Team

Mississippi Professionals Health Program
408 West Parkway Place – Ridgeland, MS 39157
(601) 420-0240 Fax (601) 707-3792

CHANGE OF ADDRESS

(Complete and fax this form to MPHP.)

Name: _____

Previous **Home** Address: _____

City, State, Zip: _____

Phone:_____ Fax:_____ Mobile: _____

New **Home** Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____ Mobile: _____

Previous **Work** Address: _____

City, State, Zip:_____

Phone:_____ Fax:_____ Mobile: _____

New **Work** Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____ Mobile: _____

Mississippi Professionals Health Program
408 West Parkway Place – Ridgeland, MS 39157
(601) 420-0240 Fax (601) 707-3792

CHANGE OF PROVIDERS

(Complete and fax this form to MPHP.)

Participant Name: _____

Previous **Primary Care Physician**: _____

New Primary Care Physician: _____

City, State, Zip: _____

Phone:_____ Fax:_____

Previous **Therapist**: _____

New Therapist: _____

City, State, Zip: _____

Phone:_____ Fax:_____

Previous **Psychiatrist**: _____

New Psychiatrist: _____

City, State, Zip: _____

Phone:_____ Fax:_____

Previous **Medication Monitor**: _____

New Medication Monitor: _____

City, State, Zip: _____

Phone:_____ Fax:_____

TALBOTT RECOVERY CAMPUS

Medication Guide

For A Safe Recovery

A guide to maintaining sobriety while receiving treatment for other health problems.

Revision 2.0 -June 2014

Table of Contents

Introduction

From the Talbott Recovery Campus

Welcome to the Talbott Recovery Campus guide for a safe and sustained recovery. This document was developed through a collaborative effort between some of the best minds in addiction care today and will help you make wise decisions, ensuring that medications you may be prescribed and incidental exposure to alcohol do not threaten your hard won recovery.

This guide is divided into three sections and is based on the drug classification system developed nearly 20 years ago by Dr. Paul Earley and recently expanded on by Bruce Merkin, M.D., Renee Enstrom, Nicholas Link and the staff at Glenbeigh hospital. Part one provides a way of categorizing medications according to their safety. Part two offers a list of liquid medications that do NOT contain alcohol. Section three was developed by Greg Skipper, M.D., FASAM and provides a list of common household products that contain ethyl alcohol and could produce a false positive on testing for alcohol. Avoiding these products will decrease the likelihood you will absorb or ingest small quantities of alcohol that could sensitize your system and threaten recovery.

Please remember that this guide is only intended as a quick reference and never as a substitute for the advice of your own personal physician. It is essential that you inform all of your personal physicians, dentists and other health care providers of your chemical dependency history so that medications can be prescribed safely and appropriately when they are deemed necessary. Never discontinue or make any changes in the doses of medication that you may have been prescribed. Doing so may result in unexpected problems such as withdrawal reactions, which in some cases can be life-threatening. The bottom line is that a recovering addict or alcoholic needs to become a good consumer. Remember that "Recovery Is Its Own Reward." Being healthy and regaining a happy life is your responsibility!

How to Use this Guide

There are many types of medications that may present a hazard to a person beginning the journey of recovery from chemical dependency. These include prescription and over-the-counter medications. The danger is not always that a recovering addict may develop a new addiction (though this certainly can happen), but that one can be led back into dependence on their drug of choice. The latest scientific research has proven that all the dependence-producing drugs act on the brain in the same way to produce addiction, despite having different effects or a different kind of "high" when taken.

In addition, if urine drug screening is part of the recovering person's continuing treatment program, use of many types of medications can result in falsely positive tests for the more highly addictive classes of drugs, resulting in negative consequences. Therefore, it is very important for a recovering person to learn about the different types of medications and drugs, as well as which ones present a special risk to continuing recovery and sobriety. The commonly available medications and drugs are divided into three classes – A, B and C – to indicate three levels of risk.

Class A drugs must be avoided completely, as they are well known to produce addiction and are the most dangerous of all. Only under very unusual conditions can Class A drugs be taken by a recovering addict or alcoholic, and only when given by a physician or dentist and with the consent of the addiction medicine physician that follows your care. These exceptional circumstances can include severe illness and injuries, including major surgery, car accidents and other trauma, and tests or procedures that can only be done under sedation or anesthesia. Medication treatments for certain psychiatric conditions are in this category as are medications used for drug detoxification. The street names for relevant drugs are also included in Class A.

The medications in Class B are also potentially dangerous, especially when taken by recovering persons without the guidance of a physician or another health care professional. However, under certain circumstances, the Class B group can be taken safely under a physician's care. We strongly urge you to have an addiction medicine specialist follow your treatment when you are prescribed these medications.

Class C medications are generally safe from the point of view of addiction recovery. However, overuse of any medication, even the common over-the-counter remedies, can result in unwanted side effects. People who have struggled with drug addiction or alcoholism must remain aware of the tendency to look for external solutions for internal problems and should avoid taking any of these medications on their own in order to medicate emotions and feelings. The tools of recovery, including participation at 12-Step fellowship meetings, working the Steps, or talking with a sponsor, counselor or doctor, provide safe and healthy ways to deal with the strong feelings that can come up at any time in early sobriety.

The three classes of medications that appear on the following pages include both the brand name (i.e. "Valium"), as well as the generic name (i.e. "diazepam"), as the majority of prescription bottles are labeled with the generic name. On the following pages, look for the brand name listed first, followed by the (generic name) in parentheses. For street drugs, the common name is listed first, and the chemical name or street name is in parentheses. For each drug group in Class A and B, there is also a brief explanation of the dangers associated with taking the medication or street drug. At the end of the document there are two reference guides. The first is a list of alcohol-free products grouped by therapeutic category. The manufacturer is listed next to each product name. The second is the *Incidental Exposure Index*, which details common OTCs and products that contain alcohol.

Class A Drugs
Absolutely Avoid

Alcohol:

Ale
Beer (including "near bear" & "non-alcoholic" forms)
Brandy
Liqueur
Malt Beverage
Whiskey
Wine
Wine Cooler

Alcohol consumption reduces social inhibitions and produces pleasure and a sense of well-being. It is a stimulant (raises blood pressure and heart rate) and a depressant. Alcohol affects the brain's reward pathways and appears to be related to interactions with dopamine, GABA, serotonin, opioid and NMDA neurotransmitter systems. The "non-alcohol" or "NA" forms of beer should not be consumed because there is a small amount of alcohol present and research shows that smell may be enough to trigger cravings and a subsequent relapse among certain alcoholics. Please note that there is a variety of cough and cold preparations that contain alcohol and that medications which can be taken in tablet form will not contain ethyl alcohol. Certain topical products, soft-gels and capsules contain ethyl alcohol and should be avoided. Please refer to the table at the end of the document for a list of alcohol-containing products to avoid.

Antitussives/Expectorants:

Ambenyl (codeine/bromodiphenhydramine)
Duratuss HD (hydrocodone/dextromethorphan)
Guiatuss (codeine/pseudoephedrine/guaifenesin)
Hycodan Tablets (hydrocodone/homatropine)
Hycodan Syrup (hydrocodone/homatropine)
Hycomine (hydrocodone/chlorpheniramine/ phenylephrine/acetaminophen/caffeine)
Hycotuss (hydrocodone/guaifenesin)
Hydromet (hydrocodone/homatropine)
Mytussin (codeine/pseudoephedrine/guaifenesin)
Nucofed (codeine/pseudoephedrine/guaifenesin)
Phenergan with Codeine (codeine/promethazine)
Robitussin AC (codeine/guaifenesin)
Tussionex PennKinetic (hydrocodone/chlorpheniramine)
Vicodin Tuss (hydrocodone/guaifenesin)

Any cough medications containing narcotics such as codeine or hydrocodone should not be used. These medications bind to opiate receptors in the central nervous system, altering the perception of and response to pain and produce generalized central nervous system depression and may alter mood or cause sedation.

Barbiturates:

Amytal (amobarbital)
Barbita (phenobarbital)
Butisol (butabarbital)
Donnatal (phenobarbital/atropine/hyoscyamine/ scopolamine)
Esgic (acetaminophen/butalbital/caffeine)
Fioricet (butalbital/acetaminophen/caffeine)
Fiorinal (butalbital/aspirin/ caffeine)
Nembutal (pentobarbital)
Seconal (secobarbital)

These medications can produce central nervous system depression ranging from mild (sedation) to hypnotic (sleep induction). As the dose is increased, coma and death can occur. These medications can also lead to an unusual excitatory response in some people.

Class A Drugs
Absolutely Avoid

Benzodiazepines:

Ativan (lorazepam)
Centrax (prazepam)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Restoril (temazepam)
Serax (oxazepam)
Tranxene (chlorazepate)
Valium (diazepam)
Versed (midazolam)
Xanax (alprazolam)

These medications can produce an immediate change in mood or affect and can cause central nervous system depression (dose related) resulting in sedation, dizziness, confusion or ataxia, which may impair physical and mental capabilities. Abrupt discontinuation or a large decrease in dose can lead to seizures, coma or death.

Hallucinogens:

Cannabis (grass, green marijuana, pot, weed)
DMT (dimethyltryptamine)
Ketamine (special K)
LSD (acid, blotter, paper, sunshine, window pane)
Kratum (Mitragyna speciosa-ketum, kratom or kratum, Thai)
Marinol (dronabinol)
MDMA (E, eckies, ecstasy, love drug, X, XTC)
Mescaline (peyote)
PCP (angel dust, phencyclidine)
Psilocybin (magic mushroom, 'shrooms)
2-CB
5-MeO-DIPT (foxy methoxy)
STP (DOM)

Hallucinogens act in the central nervous system. Using these substances can possibly lead to memory disturbances, psychosis and vivid hallucinations. Marinol is the psychoactive substance in marijuana and may cause withdrawal symptoms if stopped suddenly. *The above is only a partial list of Hullucinogens.

Inhalants:

Aerosols (hair sprays, deodorants)
Airplane Glue
Amyl Nitrate (poppers)
Butyl Nitrate (room deodorizer)
Gases (ether, chloroform, nitrous oxide, butane lighters, propane tanks, whipped cream dispensers)
Nail Polish Remover (acetone)
Paint (butane, propane, toluene)
Solvents (paint thinner, gasoline, glue, correction fluid, felt tip marker)
Varnish (xylene, toluene)

Inhalants are central nervous system depressants. Use of inhalants can cause sedation and loss of inhibitions possibly leading to liver, kidney, nerve, heart, brain, throat, nasal and lung damage up to and including coma and death.

Class A Drugs
Absolutely Avoid

Opioids:

Actiq (fentanyl oral transmucosal)
Buprenex (buprenorphine)
Combunox (oxycodone/ibuprofen)
Darvocet (propoxyphene napsylate/acetaminophen)
Darvon (propoxyphene hydrochloride)
Demerol (meperidine)
Dilaudid (hydromorphone)
Dolophine (methadone)
Duragesic (fentanyl transdermal)
Endocet (oxycodone/acetaminophen)
Heroin (down, H, horse, smack)
Kadian (morphine sulfate)
Lorcet (hydrocodone/acetaminophen)
Lortab (hydrocodone/acetaminophen)
Methadose (methadone)
MS Contin (morphine sulfate)
Norco (hydrocodone/acetaminophen)
Nubain (nalbuphine HCl)
OxyContin (oxycodone)
OxyIR (oxycodone)
Percocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Roxanol (morphine sulfate)
Roxicet (oxycodone/acetaminophen)
Roxicodone (oxycodone)
Soma Compound with Codeine (codeine/carisoprodol/aspirin)
Stadol (butorphanol)
Suboxone (buprenorphine/naloxone)
Subutex (buprenorphine)
Talacen (pentazocine/acetaminophen)
Talwin (pentazocine lactate)
Tylenol #2, #3 or #4 (codeine/acetaminophen)
Ultram (tramadol) (a non-opioid analgesic)
Vicodin (hydrocodone/acetaminophen)

Opioids bind to opiate receptors in the central nervous system causing inhibition of ascending pain pathways and altering the perception of and response to pain. Generalized central nervous system depression is also produced. Tolerance or drug dependence may result from extended use. Buprenorphine binds to mu receptors in the brain leading to a suppression of withdrawal and cravings but also feeling of euphoria. Most of the drugs in this class have the potential for drug dependency and abrupt cessation may precipitate withdrawal.

Gastrointestinal (Anti-Diarrheals):

Lomotil (atropine/diphenoxylate)
Motofen (atropine/difenoxin)

Diphenoxylate is a member of the opioid class of drugs. Atropine is added to discourage abuse for recreational purposes. At recommended doses, the atropine causes no effects but in larger doses, unpleasant symptoms are experienced. These medications should not be used because high doses may cause physical and psychological dependence with prolonged use.

Other Central Nervous System Depressants:

GHB (G, gamma-hydroxybutyrate, everclear)

This category depresses the central nervous system possibly leading to confusion, psychosis, paranoia, hallucinations, agitation, depression, seizures, respiratory depression, decreases in level of consciousness, coma and death.

Other Sedative-Hypnotics:

Ambien (zolpidem)
Doriden (glutethimide)
Librax (chlordiazepoxide/clidinium)
Lunesta (eszopiclone)
Midrin (acetaminophen/dichloralphenazone/ isometheptene)
Miltown (meprobamate)
Noctec (chloral hydrate)
Placidyl (ethchlorvynol)
Quaalude, Sopor (methaqualone)
Soma (carisoprodol)
Soma Compound (carisoprodol/aspirin)
Sonata (zaleplon)

These drugs act on the central nervous system and have the potential for drug dependency and abuse. Withdrawal symptoms can be seen if stopped suddenly.

Stimulants:

Adderall (amphetamine/dextroamphetamine)
Adipex-P (phentermine)
Cocaine (blow, coke, crack, rock, snow, white)
Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine (dextroamphetamine)
Fastin (phentermine)
Focalin (dexmethylphenidate)
Meridia (sibutramine)
Metadate (methylphenidate)
Methamphetamine (crank, crystal meth, glass, ice, speed)
Methylin (methylphenidate)
Preludin (phenmetrazine)
Ritalin (methylphenidate)
Tenuate (diethylpropion)

Stimulants cause physical and psychological addiction, impair memory and learning, hearing and seeing, speed of information processing, and problem-solving ability.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Addiction Treatments:

*****NOTE: Although the medications listed in this *Addiction Treatments* section are specifically intended to be taken for prevention of relapse to dependence upon one or more drugs, none of them are habit-forming or addictive themselves and should therefore be considered safe for recovering people to take. However, their proper use in the context of a recovery program requires monitoring by a health care professional, and it is for this reason that we place them in Class B.*****

Antabuse (disulfiram)
Campral (acamprosate)
Catapres (clonidine)
Chantix (varenicline)
Revia (naltrexone)
Symmetrel (amantadine)
Zyban (bupropion)

Naltrexone may precipitate intense withdrawal symptoms in patients addicted to opiates. Clonidine acts via autoreceptors in the locus coeruleus to suppress adrenergic hyperactivity there that is involved in the expression of the opioid withdrawal syndrome. Disulfiram is dangerous if taken with alcohol. Amantadine can cause decreased mental alertness or altered coordination. Chantix and Zyban are medications to help with nicotine (cigarettes, cigars, chewing tobacco, snuff) addiction.

Cough and Cold Preparations:

Antihistamines (Sedating)

Atarax (hydroxyzine hydrochloride)
Benadryl (diphenhydramine) OTC
Chlor-Trimeton (chlorpheniramine) OTC
Dimetane (brompheniramine) OTC
Efidac (chlorpheniramine) OTC
Periactin (cyproheptadine)
Polarmine (dexchlorpheniramine)
Tavist (clemastine) OTC
Teldrin (chlorpheniramine) OTC
Vistaril (hydroxyzine pamoate)

Sedating antihistamines should be used with caution because they have the potential to alter judgment and cause fatigue or sedation.

Antitussives/Expectorants

Benylin Cough (dextromethorphan) OTC
Comtrex (dextromethorphan) OTC
Contac (dextromethorphan) OTC
Delsym (dextromethorphan) OTC
Mucinex DM (dextromethorphan/guaifenesin) OTC
Nyquil (dextromethorphan/alcohol) OTC
Phenergan DM (promethazine/dextromethorphan)
Robitussin DM (dextromethorphan/guaifenesin)
Vicks Formula 44D (dextromethorphan) OTC

Any preparation containing dextromethorphan should be used with caution because dextromethorphan acts on opioid receptors in the brain. Respiratory depression and perceptual distortions can also be seen in those people taking large doses.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Decongestants (Many are Combination Products)

Actifed (pseudoephedrine/triprolidine) OTC
AH-chew D (phenylephrine) OTC
Alavert D (loratadine/pseudoephedrine) OTC
Allegra D (fexofenadine/pseudoephedrine)
Benzedrex Nasal Inhaler (propylhexamine) OTC
Bromfed (phenylephrine/brompheniramine)
Bromfed DM (pseudoephedrine/ brompheniramine/dextromethorphan)
Cardec DM (pseudoephedrine/ carbinoxamine/dextromethorphan)
Clarinex D (desloratadine/pseudoephedrine)
Claritin D (loratadine/pseudoephedrine) OTC
Deconamine SR (pseudoephedrine/ chlorpheniramine) OTC
Dimetapp (pseudoephedrine/brompheniramine)OTC
Duratuss (pseudoephedrine/guaifenesin)
Entex LA (phenylephrine/guaifenesin)
Entex PSE (pseudoephedrine/guaifenesin)
Humibid DM (pseudoephedrine/ dextromethorphan/ potassium guaiacolsulfonate)
Mucinex D (pseudoephedrine/guaifenesin) OTC
Nalex-A (phenylephrine) OTC
Novafed (pseudoephedrine) OTC
Profen (pseudoephedrine) OTC
Prolex-D (phenylephrine) OTC
R-Tannate Pediatric (phenylephrine/ chlorpheniramine/pyrilamine)
Rondec (phenylephrine/chlorpheniramine)
Rondec DM (phenylephrine/chlorpheniramine/ dextromethorphan)
Rynatan-S (phenylephrine/chlorpheniramine/ pyrilamine)
Semprex-D (pseudoephedrine/acrivastine)
Sinutuss DM (phenylephrine) OTC
Sudafed (pseudoephedrine) OTC
Tussafed-EX (phenylephrine) OTC
Zyrtec D (cetirizine/pseudoephedrine)

Decongestants should be used with caution because they are stimulating and can trigger relapse.

Nasal Sprays

Afrin (oxymetazoline) OTC
Astelin (azelastine)
Dristan (oxymetazoline) OTC
Flonase (fluticasone)
Nasacort AQ or HFA (triamcinolone)
Nasonex (mometasone)
Neo-synephrine (phenylephrine) OTC
Nostrilla (oxymetazoline) OTC
Rhinocort Aqua (budesonide)
Vicks Nasal Inhaler (desoxyephedrine) OTC
Vicks Sinex (phenylephrine) OTC
4-Way Nasal Spray (phenylephrine) OTC

All OTC nasal sprays should be used for a short period of time. If used for a long period of time symptoms may worsen. Use for a maximum of 5 days. Intranasal corticosteroids (non-OTC) may cause a reduction in growth velocity in pediatric patients.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Muscle Relaxants:

Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Parafon Forte (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Zanaflex (tizanidine)

Muscle relaxants can cause central nervous system depression (sedation, dizziness), which may impair physical or mental abilities.

Neuropathic Pain:

Lyrica (pregabalin)

Lyrica acts in the central nervous system as a depressant and can lead to withdrawal symptoms upon discontinuation. It also produces euphoria in certain individuals.

Sleep Aids:

Excedrin PM (diphenhydramine) OTC
Nytol (diphenhydramine) OTC
Sleep-eze (diphenhydramine) OTC
Sominex (diphenhydramine) OTC
Tylenol PM (diphenhydramine/acetaminophen) OTC
Unisom (diphenhydramine) OTC

Sleep aids act in the central nervous system and can alter judgement and cause sedation.

Others:

Asthma

Primatene Mist (epinephrine) OTC

Primatene Mist can cause nervousness, restlessness, sleeplessness, palpitations, tachycardia, chest pain, muscle tremors, dizziness and flushing.

Steroids

Decadron (dexamethasone)
Deltasone (prednisone)
Medrol (methylprednisolone)

It is important to take steroids exactly as directed. Long term use requires a taper off of the drug. Steroid use can decrease the immune system leading to increased infections. Insomnia, nervousness and a variety of other side effects are also common.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Asthma/COPD/Pulmonary (Inhaled Corticosteroids/Long-Acting Beta 2 Agonists)

Advair Diskus (fluticasone/salmeterol)
Azmacort (traimcinolone)
Flovent (fluticasone)
Pulmicort (budesonide)
Serevent Diskus (salmeterol)
QVAR (beclomethasone)

Particular care is required when patients are transferred from systemic corticosteroids to inhaled products due to possible adrenal insufficiency or withdrawal from steroids, including an increase in allergic symptoms. Regular use may suppress the immune system. Orally-inhaled corticosteroids may cause a reduction in growth velocity in pediatric patients. Advair and Serevent can cause central nervous system excitement.

Gastrointestinal (Constipation)

Dulcolax (bisacodyl) OTC
Ex-Lax (senna) OTC
Senokot (senna) OTC

Continued use of laxatives can lead to dependency for colon function. Use for only a short period of time.

Gastrointestinal (Nausea/Vomiting)

Compazine (prochlorperazine)
Phenergan (promethazine)
Tigan (trimethobenzamide)
Zofran (ondansetron)

These medications affect the central nervous system and can cause sedation.

Vertigo/Motion Sickness

Antivert (meclizine)
Dramamine (dimenhydrinate) OTC
Transderm Scop (scopolamine)

These medications affect the central nervous system and can cause dizziness, drowsiness or blurred vision.

Class C Drugs
Generally Safe to Take

Alzheimer's:
Aricept (donepezil)
Exelon (rivastigmine)
Namenda (memantine)
Razadyne (galantamine)

Analgesics (Migraine):
Amerge (naratriptan)
Axert (almotriptan)
Frova (frovatriptan)
Imitrex (sumatriptan)
Maxalt (rizatriptan)
Relpax (eletriptan)
Zomig (zolmitriptan)

Analgesics (Other):
Tylenol (acetaminophen) OTC

Anti-Convulsants (Also Mood Stabilizers):
Carbatrol (carbamazepine)
Depakote (divalproex sodium)
Dilantin (phenytoin)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zonegran (zonisamide)

Antihistamines (Non-sedating):
Alavert (loratadine) OTC
Allegra (fexofenadine)
Clarinex (desloratadine)
Claritin (loratadine) OTC
Zyrtec (cetirizine)

Antibiotics/Antivirals:
Amoxil (amoxicillin)
Augmentin (amoxicillin/clavulanate)
Avelox (moxifloxacin)
Bactrim (sulfamethoxazole/trimethoprim)
Biaxin (clarithromycin)
Ceclor (ceflacor)
Ceftin (cefuroxime)
Cefzil (cefprozil)
Cipro (ciprofloxacin)
Cleocin (clindamycin)
Diflucan (fluconazole)
Doryx (doxycycline)
Duricef (cefadroxil)
E-Mycin (erythromycin)
Flagyl (metronidazole)
Keflex (cephalexin)
Ketek (telithromycin)
Levaquin (levofloxain)
Lorabid (loracarbef)
Macrobid (nitrofurantoin monohydrate/macrocrystals)
Macrodantin (nitrofurantoin macrocrystals)
Minocin (minocycline)
Omnicef (cefdinir)
Pen-Vee K (penicillin)
Relenza (zanamavir)
Sporanox (itraconazole)
Sumycin (tetracycline)
Tamiflu (oseltamavir)
Tequin (gatifloxacin)
Valtrex (valacyclovir)
Vantin (cefpodoxime)
Vibramycin (doxycycline)
Zithromax (azithromycin)
Zovirax (acyclovir)

Class C Drugs
Generally Safe to Take

Anti-Parkinsonians:
Mirapex (pramipexole)
Requip (ropinirole)
Sinemet (carbidopa/levodopa)

Antitussives/Expectorants:
Humibid LA (guaifenesin/potassium guaiacolsulfonate)
Mucinex (guaifenesin) OTC
Tessalon Perles (benzonatate)

Asthma/COPD/Pulmonary:
Accolate (zafirlukast)
Atrovent (ipratropium)
Combivent (albuterol/ipratropium)
Proventil/Ventolin (albuterol)
Singulair (montelukast)
Spiriva (tiotropium)
Theo-24 (theophylline)
Xopenex (levalbuterol)

Benign Prostatic Hypertrophy (Also Cardiovascular):
Cardura (doxazosin)
Flomax (tamsulosin)
Hytrin (terazosin)
Proscar (finasteride)

Cardiovascular (Antihypertensives, Anticoagulants, Antiplatelets, Cholesterol Lowering, Diuretics):
Accupril (quinapril)
Aldactone (spironolactone)
Altace (ramipril)
Aspirin
Atacand (candesartan)
Avalide (irbesartan/hydrochlorothiazide)
Avapro (irbesartan)
Benicar (olmesartan)
Betapace (sotalol)
Bumex (bumetadine)
Calan (verapamil)
Cardizem (diltiazem)
Coreg (carvedilol)
Coumadin (warfarin)
Cozaar (losartan)
Crestor (rosuvastatin)
Demadex (torsemide)
Diovan (valsartan)
Dyazide (hydrochlorothiazide/triamterene)
Heparin
Hydrodiuril (hydrochlorothiazide)
Hyzaar (losartan/hydrochlorothiazide)
Imdur (isosorbide mononitrate)
Inderal (propranolol)
Isordil (isosorbide dinitrate)
Lanoxin (digoxin)
Lasix (furosemide)
Lipitor (atorvastatin)
Lopid (gemfibrozil)
Lopressor (metoprolol)
Lotensin (benazepril)
Lotrel (amlopidine/benazepril)
Lovenox (enoxaparin)
Monopril (fosinopril)
Niaspan (Niacin)
Nitro-Bid (nitroglycerin)
Norvasc (amlopidine)
Plavix (clopidogrel)
Pravachol (pravastatin)
Prinivil (lisinopril)
Sular (nisoldipine)
Tenormin (atenolol)
Tricor (fenofibrate)
Vasotec (enalapril)
Vytorin (ezetimibe/simvastatin)
Zestril (lisinopril)
Zetia (ezetimibe)
Zocor (simvastatin)

Class C Drugs
Generally Safe to Take

Diabetes Mellitus:
Actos (pioglitazone)
Amaryl (glimepiride)
Avandia (rosiglitazone)
Diabeta (glyburide)
Glucophage (metformin)
Glucotrol (glipizide)
Humalog (insulin lispro)
Humulin L,N,R,U (insulin)
Lantus (insulin glargine)
Novolin 70/30, N or R (insulin)
Novolog (insulin aspart)

Erectile Dysfunction:
Cialis (tadalafil)
Levitra (vardenafil)
Viagra (sildenafil)

Gastrointestinal (Antacids, Anti-diarrheals, Anti-Spasmosdics, Anti-Ulcers, Constipation, Nausea/ Vomiting):
Aciphex (rabeprazole)
Bentyl (dicyclomine)
Colace (docusate sodium) OTC
Emetrol (phosphorylated carbohydrate) OTC
Imodium (loperamide) OTC
Kaopectate (bismuth subsalicylate) OTC
Maalox OTC
Mylanta OTC
Nexium (esomeprazole)
Pepcid (famotidine) OTC
Pepto-Bismol (bismuth subsalicylate) OTC
Prevacid (lansoprazole)
Prilosec (omeprazole) OTC
Protonix (pantoprazole)
Reglan (metoclopramide)
Simethicone OTC
Tums OTC
Zantac (ranitidine) OTC

Genitourinary:
Detrol (tolterodine)
Ditropan (oxybutinin)

Glaucoma:
Alphagan P (brimonidine)
Azopt (brinzolamide)
Cosopt (dorzolamide/timolol)
Lumigan (bimatoprost)
Timoptic (timolol)
Travatan (travoprost)
Trusopt (dorzolamide)
Xalatan (latanoprost)

Gout:
Zyloprim (allopurinol)

Nasal Sprays:
Atrovent (ipratropium)
Ayr (saline) OTC
HuMist (saline) OTC
NaSal (saline) OTC
NasalCrom (cromolyn) OTC
Ocean Spray (saline) OTC

Class C Drugs
Generally Safe to Take

Non-Steroidal Anti-Inflammatory Drugs:
Advil (ibuprofen) OTC
Aleve (naproxen) OTC
Anaprox (naproxen)
Cataflam (diclofenac potassium)
Daypro (oxaprozin)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Motrin (ibuprofen) OTC
Naprosyn (naproxen)
Orudis (ketoprofen)
Relafen (nabumetone)
Toradol (ketorlac)
Voltaren (diclofenac sodium)

COX-2 inhibitors:
Celebrex (celecoxib)

Osteoporosis (Calcium Metabolism):
Actonel (risedronate)
Boniva (ibandronate)
Evista (raloxifene)
Fosamax (alendronate)

Psychotropics:
Abilify (aripiprazole)
Buspar (buspirone)
Celexa (citalopram)
Clozaril (clozapine)
Cymbalta (duloxetine)
Depakote (divalproex sodium)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Eskalith (lithium)
Geodon (ziprasidone)
Haldol (haldoperidol)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Risperdal (risperidone)
Seroquel (quetiapine)
Serzone (nefazodone)
Sinequan (doxepin)
Sinequan (doxepin)
Strattera (atomoxetine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Zyprexa (olanzapine)

Sleep Aid:
Rozerem (ramelteon)

Thyroid:
Armour thyroid (thyroid desiccated)
Levothroid (levothyroxine)
Levoxyl (levothyroxine)
Synthroid (levothyroxine)

Alcohol-Free Products

The following is a selection of alcohol-free products grouped by therapeutic category. The list is not comprehensive. Manufacturers change product ingredients and brand names frequently. Always check product labeling for definitive information on specific ingredients. Manufacturers are listed after each product name. Please note that some of these medications, while alcohol-free, do contain compounds with addiction liability and are thus Class B medications. Such products are preceded by an asterisk (*).

Analgesics:

Acetaminophen Infants Drops	**Ivax**
Actamin Maximum Strength Liquid (acetaminophen)	**Cypress**
Addaprin Tablet (ibuprofen)	**Dover**
Advil Children's Suspension (ibuprofen)	**Wyeth Consumer**
Aminofen Tablet (acetaminophen)	**Dover**
Aminofen Max Tablet (acetaminophen)	**Dover**
APAP Elixir (acetaminophen)	**Bio-Pharm**
Aspirtab Tablet (aspirin)	**Dover**
Genapap Children Elixir (acetaminophen)	**Ivax**
Genapap Infant's Drops (acetaminophen)	**Ivax**
Motrin Children's Suspension (ibuprofen)	**McNeil Consumer**
Motrin Infants' Suspension (ibuprofen)	**McNeil Consumer**
Silapap Children's Elixir (acetaminophen)	**Silarx**
Silapap Infant's Drops (acetaminophen)	**Silarx**
Tylenol Children's Suspension (acetaminophen)	**McNeil Consumer**
Tylenol Extra Strength Solution (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Drops (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Suspension (acetaminophen)	**McNeil Consumer**

Anti-Asthmatic Agents:

Dilor-G Liquid (guaifenesin/dyphylline)	**Savage**
Elixophyllin-GG liquid (guaifenesin/theophylline)	**Forest**

Anti-Convulsants:

Zarontin Syrup (Ethosuximide)	**Pfizer**

Antiviral Agents:

Epivir Oral Solution (Lamivudine)	**GlaxoSmithKline**

Cough/Cold/Allergy Preparations:

***Accuhist Pediatric Drops** (brompheniramine/pseudoephedrine)	**Propst**
***Alka Seltzer Plus Day Cold** (acetaminophen, dextromethorphan, phenylephrine)	**Bayer**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

*Alka Seltzer Plus Night Cold (acetaminophen, dextromethorphan, phenylephrine, chlorpheniramine, doxylamine)	Bayer
*Allergy Relief Medicine Children's Elixir (diphenhydramine)	Hi-Tech Pharmacal
*Andehist DM Drops (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM Syrup (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM NR Liquid (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist DM NR Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist NR Syrup (carbinoxamine/pseudoephedrine)	Cypress
*Bayer Alka Seltzer Plus Cold & Cough (acetaminophen, dextromethrophan, phenylephrine, chlorpheniramine)	Bayer
*Benadryl Allergy Solution (diphenhydramine)	Pfizer Consumer
*Biodec DM Drops (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Biodec DM Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Broncotron Liquid (pseudoephedrine)	Seyer Pharmatec
*Buckleys Mixture, (dextromethorphan)	Novartis
Carbatuss Liquid (phenylephrine/guaifenesin)	GM
Cepacol Sore Throat Liquid (benzocaine)	J.B. Williams
*Children's Benadryl Allergy, (diphenhydramine)	Pfizer
*Chlor-Trimeton Allergy Syrup (chlorpheniramine)	Schering Plough
*Codal-DM Syrup (dextromethorphan/phenylephrine/pyrilamine)	Cypress
*Creomulsion Complete Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Creomulsion Cough Syrup (dextromethorphan)	Summit Industries
*Creomulsion For Children Syrup (dextromethorphan)	Summit Industries
*Creomulsion Pediatric Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Delsym Cough Suppressant (dextromethorphan)	Cell Tech
*Despec Liquid (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin/ phenylephrine)	International Ethical
*Diabetic Tussin Allergy Relief Liquid (chlorpheniramine)	Healthcare Products
*Diabetic Tussin DM Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Capsule (guaifenesin/dextromethorphan)	Healthcare Products
Diabetic Tussin EX Liquid (guaifenesin)	Healthcare Products
*Diabetic Tussin Nighttime Formula Cold/Flu Relief (dextromethrophan, acetaminophen, diphenhydramine)	Healthcare Products
*Dimetapp Cold & Fever Children's Suspension (ibuprofen/pseudoephedrine)	Wyeth Consumer
*Double-Tussin DM Liquid (guaifenesin/dextromethorphan)	Reese
*Dynatuss Syrup (carbinoxamine/pseudoephedrine/dextromethorphan)	Breckenridge
*Dynatuss EX Syrup (guaifenesin/dextromethorphan/pseudoephedrine)	Breckenridge
*Entex Syrup (phenylephrine/guaifenesin)	Andrx

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Father John's Medicine Plus Drops** (chlorpheniramine/ phenylephrine/ dextromethorphan/ guaifenesin/ammonium chloride)	**Oakhurst**
***Friallergia DM Liquid** (brompheniramine/pseudoephedrine/dextromethorphan)	**R.I.D.**
***Friallergia Liquid** (brompheniramine/pseudoephedrine)	**R.I.D.**
***Gani-Tuss-DM NR Liquid** (guaifenesin/dextromethorphan)	**Cypress**
***Genahist Elixir** (diphenhydramine)	**Ivax**
***Giltuss Pediatric Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Giltuss Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Guaicon DMS Liquid** (guaifenesin/dextromethorphan)	**Textilease Medique**
***Guai-Dex Liquid** (guaifenesin/dextromethorphan)	**Alphagen**
***Guaifed Syrup** (phenylephrine/pseudoephedrine/guaifenesin)	**Muro**
***Hayfebrol Liquid** (chlorpheniramine/pseudoephedrine)	**Scot-Tussin**
***Histex Liquid** (chlorpheniramine/pseudoephedrine)	**TEAMM**
Histex PD Drops (carbinoxamine)	**TEAMM**
Histex PD Liquid (carbinoxamine)	**TEAMM**
***Hydramine Elixir**(diphenhydramine)	**Ivax**
***Hydro-Tussin DM Elixir** (guaifenesin/dextromethorphan)	
***Kita La Tos Liquid** (guaifenesin/dextromethorphan)	**R.I.D.**
***Lodrane Liquid** (brompheniramine/pseudoephedrine)	**ECR**
***Medi-Brom Elixir** (brompheniramine/pseudoephedrine/dextromethorphan)	**Medicine Shoppe**
***Motrin Cold Children's Suspension** (ibuprofen/pseudoephedrine)	**McNeil Consumer**
***Nalex-A Liquid** (chlorpheniramine/phenylephrine)	**Blansett Pharmacal**
***Nalspan Senior DX Liquid** (guaifenesin/dextromethorphan)	**Morton Grove**
***Neotuss-D Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**A.G. Marin**
***Norel DM Liquid** (chlorpheniramine/phenylephrine/ dextromethorphan)	**U.S. Pharmaceutical**
Orgadin Liquid (guaifenesin)	**American Generics**
Organidin NR Liquid (guaifenesin)	**Wallace**
***Palgic-DS Syrup** (carbinoxamine/pseudoephedrine)	**Pamlab**
***Panmist DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	**Pamlab**
***Panmist-S Syrup** (guaifenesin/pseudoephedrine)	**Pamlab**
***PediaCare Cold + Allergy Children's Liquid** (chlorpheniramine/pseudoephedrine)	**Pharmacia**
***PediaCare Cough + Cold Children's Liquid** (chlorpheniramine/ pseudoephedrine/ dextromethorphan)	**Pharmacia**
***PediaCare Nightrest Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Pharmacia**
***Pediahist DM Syrup** (brompheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**Boca**
***Pedia-Relief Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Major**
Pediatex Liquid (carbinoxamine)	**Zyber**
***Pediatex-D Liquid** (carbinoxamine/pseudoephedrine)	**Zyber**
Phanasin Syrup (guaifenesin)	**Pharmakon**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

Phanatuss Syrup (guaifenesin)	**Pharmakon**
***Phena-S Liquid** (chlorpheniramine/phenylephrine)	**GM**
***Poly-Tussin DM Syrup** (chlorpheniramine/phenylephrine/dextromethorphan)	**Poly**
***Primsol Solution**(trimethoprim)	**Medicis**
***Prolex DM Liquid** (guaifenesin/dextromethorphan)	**Blansett Pharmacal**
***Quintex Syrup** (phenylephrine/guaifenesin)	**Qualitest**
***Robitussin Cough & Congestion Liquid** (chlorpheniramine/pseudoephedrine/ dextromethorphan/guaifenesin/acetaminophen)	**Wyeth Consumer**
***Robitussin Cough & Cold Nightime** (chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin Cough & Allergy** (chlorpheniramine, dextromethorphan, phenylephrine	**Wyeth**
***Robitussin Cough & Cold CF** (dextromethorphan, guaifenesin, phenylephrine)	**Wyeth**
***Robtiussin Cold & Flu Nightime** (acetaminophen, chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin DM Liquid** (guaifenesin/dextromethorphan)	**Wyeth Consumer**
***Robitussin PE Syrup** (pseudoephedrine/guaifenesin)	**Wyeth Consumer**
***Robitussin Pediatric Drops** (guaifenesin/dextromethorphan/pseudoephedrine)	**Wyeth Consumer**
***Robitussin Pediatric Night Relief Liquid** (chlorpheniramine/dextromethorphan/ pseudoephedrine)	**Wyeth Consumer**
***Scot-Tussin Allergy Relief Formula Liquid** (diphenhydramine)	**Scot-Tussin**
***Scot-Tussin DM Liquid** (chlorpheniramine/dextromethorphan/guaifenesin)	**Scot-Tussin**
***Scot-Tussin Expectorant Liquid** (guaifenesin)	**Scot-Tussin**
***Scot-Tussin Original Syrup** (phenylephrine)	**Scot-Tussin**
***Scot-Tussin Senior Liquid** (guaifenesin/dextromethorphan)	**Scot-Tussin**
***Sildec Liquid** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec Syrup** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec-DM Drops** (brompheniramine/pseudoephedrine/carbinoxamine/dextromethorphan)	**Silarx**
***Sildec-DM Syrup** (brompheniramine/pseudoephedrine/ carbinoxamine/dextromethorphan)	**Silarx**
Siltussin DAS Liquid (guaifenesin)	**Silarx**
***Siltussin DM Syrup** (guaifenesin/dextromethorphan)	**Silarx**
***Siltussin DM DAS Cough Formula Syrup** (guaifenesin/dextromehtorphan)	**Silarx**
Siltussin SA Syrup (guaifenesin)	**Silarx**
***Simply Cough Liquid** (dextromehtorphan)	**McNeil Consumer**
***Sudatuss DM Syrup** (chlorpheniramine/dextromethorphan/pseudoephedrine)	**Pharmaceutical Generic**
***Tussafed Syrup** (chlorpheniramine/carbinoxamine/ pseudoephedrine/dextromethorphan)	**Everett**
***Tussafed-EX Syrup** (pseudoephedrine/dextromethorphan/guaifenesin)	**Everett**
***Tuss-DM Liquid** (chlorpheniramine/phenylephrine/guaifenesin/dextromethorphan	**Seatrace**
***Tussi-Organidin DM NR Liquid** (guaifenesin/dextromethorphan)	**Wallace**
***Tussi-Pres Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Kramer-Novis**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Tylenol Cold Children's Liquid** (chlorpheniramine/pseudoephedrine/acetaminophen)	McNeil Consumer
***Tylenol Cold Infants' Drops** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Tylenol Flu Children's Suspension** (chlorpheniramine/pseudoephedrine/ dextromethorphan/acetaminophen)	McNeil Consumer
***Tylenol Flu Night Time Max Strength Liquid** (acetaminophen/ doxylamine/ diphenhydramine/pseudoephedrine/dextromethorphan)	McNeil Consumer
***Tylenol Sinus Children's Liquid** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Vicks Dayquil Multi-symptom cold/flu relief** (acetaminophen, dextromethorphan, phenylephrine)	Procter & Gamble
***Vicks 44E Pediatric Liquid** (guaifenesin/dextromethorphan)	Procter & Gamble
***Vicks 44M Pediatric Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	Procter & Gamble
***Z-Cof DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	Zyber

Ear/Nose/Throat Products:

4-Way Saline Moisturizing Mist Spray	Bristol-Myers
Ayr Baby Saline Spray	Ascher, B.F.
Bucalcide Solution (benzocaine)	Seyer Pharmatec
Bucalcide Spray (benzocaine)	Seyer Pharmatec
Bucalsep Solution (benzocaine)	Gil
Bucalsep Spray (benzocaine)	Gil
Cepacol Sore Throat Liquid (benzocaine)	Combe
Gly-oxide Liquid (carbamide peroxide)	GlaxoSmithKline
Consumer Orasept Mouthwash/Gargle Liquid (benzocaine)	Pharmakon Labs
Zilactin Baby Extra Strength Gel (benzocaine)	Zila Consumer

Gastrointestinal Agents

Imogen Liquid (loperamide)	Pharmaceutical
Kaopectate (bismuth subsalicyate)	Ethex

Generic

Kaopectate Suspension (bismuth subsalicylate)	Pharmacia

Consumer

Liqui-Doss Liquid (mineral oil)	Ferndale

Hematinics

Irofol Liquid (iron)	Dayton

Alcohol-Free Products

Miscellaneous

Cytra-2 Solution (sodium citrate salts)	Cypress
Cytra-K Solution (sodium citrate salts)	Cypress
Emetrol Solution (phosphorated carbohydrate)	Pharmacia Consumer

Psychotropics

***Thorazine Syrup** (chlorpromazine)	GlaxoSmithKline

Topical Products

Aloe Vesta 2-N-1 Antifungal Ointment (miconazole)	Convatec
Fleet Pain Relief Pads (pramoxine)	Fleet
Neutrogena Acne Wash Liquid	Neutrogena
Neutrogena Antiseptic Liquid	Neutrogena
Neutrogena Clear Pore Gel	Neutrogena
Neutrogena T/Derm Liquid	Neutrogena
Neutrogena Toner Liquid	Neutrogena
Podiclens Spray (benzalkonium chloride)	Woodward
Sea Breeze Foaming Face Wash Gel	Clairol

Vitamins/Minerals/Supplements

Apetigen Elixir (vitamins A & E/multivitamin)	Pharmaceutical Generic
Genesupp-500 Liquid (multivitamin)	Pharmaceutical Generic
Genetect Plus Liquid (multivitamin/iron)	Pharmaceutical Generic
Multi-Delyn w/Iron Liquid (multivitamin/iron)	Silarx
Poly-Vi-Sol Drops (multivitamin)	Mead Johnson
Poly-Vi-Sol w/Iron Drops (multivitamin/iron)	Mead Johnson
Strovite Forte Syrup (multivitamin/iron/folic acid)	Everett
Supervite Liquid (multivitamin/B complex/folic acid/multivitamin)	Seyer Pharmatec
Suplevit Liquid (multivitamin/iron)	Gil
Tri-Vi-Sol Drops (multivitamin)	Mead Johnson
Tri-Vi-Sol w/Iron Drops (multivitamin/iron)	Mead Johnson
Vitafol Syrup (multivitamin/iron/folic acid/vitamin E/calcium salts)	Everett

Incidental Exposure Index

New markers for alcohol use, ethylglucuronide (EtG), ethylsulfate (EtS) and others, have added tremendous value to routine drug testing by their capacity to better document abstinence (allowing for more authoritative advocacy) and sensitively to detect early relapse (allowing for earlier assistance). Since these new markers are highly sensitive, it's important that individuals being tested try to avoid exposure to products containing alcohol that might cause positive tests. This issue is identical to that of avoiding poppy seeds to avoid a positive test for morphine. However, there are many more products containing alcohol. ***Please note that this list is not exhaustive, therefore it is recommended that patients check labels or with manufacturers before using.***

Possible Sources of Incidental Exposure

Foods

Foods can contain trace amounts or large quantities of alcohol. Avoid desserts and other foods cooked with or containing alcoholic beverages such as vodka, sherry, wine, etc. Also avoid foods containing significant amounts of vanilla extract (especially if added to drinks), wine vinegar, soy sauces and other condiments with alcohol content on their labels.

Hygiene Products

Many hygiene related products, such as mouthwashes, contain alcohol and should be avoided. For a comprehensive list of hygiene products that contain alcohol, please read the *Alcohol-Containing Products Table* on the following pages.

Over-the-Counter Medications

Over-the-counter medications, such as cough syrup and tinctures, contain alcohol and should be avoided. Please review the *Over-the-Counter Medications Alcohol Content Table* on the following pages for a more detailed breakdown of OTCs that contain alcohol.

Prescription Medications

Many prescription medications, including asthma inhalers, contain alcohol or ethanol. Always ask your health care provider prior to taking any prescription medications.

Other Sources of Alcohol

Alcohol can be found in many common products including communion wine and "alcohol-free" beer and wine. Recovering patients should also avoid products like hand sanitizers, deodorant sprays, cosmetics and insecticides that contain ethanol vapor and can be inhaled or absorbed through skin application.

Alcohol-Containing Products Table

The following is a list of products and their alcohol contents. Not all of these would actually be likely to be sources of incidental exposure and some would result in very toxic effects if there was much exposure (i.e. Clorox).

Product	*Alcohol %*
ABIN Primer & Sealer	35
Afta After Shave Skin Conditioner 3 OZ.	5-15
Afta Pre-Electric Shave Lotions	50-60
Ajax Antibacterial Dishwashing Liquid 19 OZ.	5-10
Ajax Dishwashing Liquid Antibacterial Hand Soap 38 OZ.	1-5
Aqua Mix Laminate Plus	<9
Aqua Mix Tile Plus More Cleaner-10/31/2000	<9
Ariel Liquid Laundry Detergent	1-5
Armor All Odor Eliminator	3-7
Armor All Odor Eliminator-01/01/2001	1-10
Arrid Total Gel-All Scents	7-12
Avon Black Suede After Shave	60-98
Avon Black Suede Cologne Spray	60-98
Avon Clearskin Targeted Blemish Remover	9.995
Avon Dreamlife Eau de Parfum Spray	60-98
Avon Far Away Sensual Embrace Eau de Parfum Spray	60-98
Avon Ginger Scents Spray Ginger Fresh Body Mist	60-98
Avon Haiku Eau de Parfum Spray	60-98
Avon Imari Eau de Cologne Spray	60-98
Avon Intrigue Cologne Spray	60-98
Avon Lil Hugs Gentle Splash	60-98
Avon Little Black Dress Eau de Parfum Spray	60-98
Avon Memorable Eau de Parfum Spray	60-98
Avon Mesmerize for Men Cologne Spray	60-98
Avon Midnight Frost Fragrance Spray	60-98
Avon Moisture Effective Eye Makeup Remover Lotion	60-98
Avon MUSK FOR BOYS	60-98
Avon NAIL EXPERTS Strong Results	21.74
Avon NATURALS Body Spray, Almond	60-98
Avon NATURALS Body Spray, Cucumber Melon	60-98
Avon NATURALS Body Spray, Gardenia	60-98
Avon NATURALS Body Spray, Lily	60-98
Avon NATURALS Body Spray, Peach	60-98
Avon NATURALS Body Spray, Plumeria	60-98
Avon NATURALS Body Spray, Raspberry	60-98

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Avon NATURALS Body Spray, Sea	60-98
Avon NATURALS Body Spray, Vanilla	60-98
Avon Night Evening Magic Cologne Spray	60-98
Avon Passion Dance for Men	60-98
Avon Passion Dance for Women	60-98
Avon Perceive Eau de Parfum Spray for Women	60-98
Avon Perceive For Men Cologne Spray	60-98
Avon Pink Suede Eau de Toilette Spray	60-98
Avon Planet Spa White Tea Energizing Face and Body Mist	60-98
Avon Prospect Eau de Toilette Spray	60-98
Avon Radiant Moments Body Spray	60-98
Avon RARE GOLD Eau de Parfum Spray	60-98
Avon RARE PEARLS Eau de Parfum Spray	60-98
Avon Simply Radiant Shimmering Body Spray	60-98
Avon Vintage Cologne Spray	60-98
Avon WILD COUNTRY After Shave	60-98
Avon WILD COUNTRY Cologne Spray	60-98
Avon Wild Country Outback After Shave Lotion	60-98
Avon Wild Country Outback Eau De Toilette Spray	60-98
Bath & Body Instant Anti-Bacterial Hand Gel-Freesia	60
Bay Rum After Shave Balm	30
Bold Liquid Laundry Detergent	1-5
Bravo Platinum Series Metered Air Freshener	15-25
Bulls Eye Clear Shellac	55
Cascade Crystal Clear Plus Shine Shield Rinse Agent 8.45 fl oz	3-7
Cheer Liquid Laundry Detergent	1-5
Clorox Dual Action Toilet Bowl Cleaner 1 Pt. 9 Fl. Oz. (Chambered Bottle)	1-5
Clorox Spring Mist Disinfecting Spray-Floral Fresh 18 Oz. (aerosol)	60-80
Cutter All Family Insect Repellent 2 Aerosol	35
Cutter All Family Insect Repellent Mosquito Repellent Pump Spray	39
Cutter Insect Repellent	17
Cutter Skinsations Insect Repellent 1, Aloe & Vitamin E, Clean Fresh Scent	50
Cutter Unscented Backwoods Insect Repellent, Water-Resistant Sport Formula, Aerosol	35
Cutter Unscented Backwoods Mosquito Wipes	29
Cutter Unscented Insect Repellent	37
Cutter Unscented Outdoorsman Insect Repellent II Pump Spray	44
Cutter Unscented Outdoorsman Insect Repellent, Water-Resistant Sport Formula, Aerosol	20

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
DAP Easy Bond Adhesive	1.0-5.0
Dawn Manual Pot and Pan Detergent	5-10
Dawn Manual Pot and Pan Detergent (Professional Line)	5-10
Deep Woods OFF!	50-60
Deep Woods Off! Pump Spray	30-40
Dermassage Dishwashing Hand Liquid - Regular	1-5
Downy Advanced w/Wrinkle Control Fabric Softener (Clean Breeze, Mountain Spring)	1-5
Downy Enhancer	1-5
Downy Enhancer (Invigorating Burst and Calming Mist)	1-5
Downy Premium Care	1-5
Dreft Liquid Laundry Detergent	1-5
Easy Off Heat Activated Microwave Wipes	5-10
Era Liquid Laundry Detergent	1-5
Fab Color Plus Ultra Power	1-5
Farnam Cologne & Deodorant for Pets	20
Febreze Air Effects 9.7 oz Blossoms and Breeze	3-7
Febreze Air Effects 9.7 oz Citrus and Light	3-7
Febreze Air Effects 9.7 oz Spring and Renewal	3-7
Febreze Concentrated Fabric Refresher	12-17
Febreze Fabric Refresher	1-5
Fire Up II Firestarter	<85
Gain Liquid Laundry Detergent	1-5
Giant Auto Dish Detergent 75 OZ BOX	1-5
Giant Pure Power Auto Dish Detergent Lemon 45 OZ BOX	1-5
Glade Fragrant Mist Country Garden	7-13
Glass Mates	4.0-6.0
Glass Mates-05/16/2000	4.0-6.0
HOUSE SAVER Pet Stain & Odor Remover	20
Invisible Shield Surface Protectant-04/11/2002	78
Ivory Snow Liquid Laundry Detergent	1-5
KimCare Instant Hand Sanitizer	60
Lady Speed Stick Clear Antiperspirant Deodorant Gel	15-20
Listerine Antiseptic Mouthwash	26.9
Listerine Cool Mint Antiseptic Mouthwash	23
Listerine Fresh Burst Antiseptic Mouthwash	23
Listermint Mouthwash	<10
Loctite Crafter's All Purpose Adhesive	3-5

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Loctite Fabric Glue	3-5
Loctite Outdoor Fixture Adhesive	1-5
LOreal Pumping Curls for Curly Hair	41
Lysol Brand Antibacterial Hand Gel	63
Lysol Brand Disinfectant Spray, Antibacterial, Original Scent	79.0
Lysol Brand II Disinfectant Plus Fabric Refresher 12 oz	85
Lysol Brand II Disinfectant Spray-Country Scent (aerosol)	79
Lysol Brand Sanitizing Wipes-Citrus Scent	8-10
Lysol Brand Sanitizing Wipes-Spring Waterfall 52 oz	8-10
Lysol Brand Scrubbing Wipes-Orange Breeze Scent	8-12
Martin Weber Blue Label Fixatif Spray	60-70
Martin Weber Cleaning Solution	31
Mr Muscle Pot & Pan Detergent	3-7
Nair Hair Remover Kit, Cold Wax Strips Pretreatment Towelette	5-20
New-Skin Liquid Bandage	5
Nilodor Air Freshener-Floral	0.5-3.5
Nilodor Carpet Care Deodorizing Spot/Stain Remover	2-6
Nilodor Deodorizing Carpet Extractor	2-6
Nilodor Odor Neutralizer	0.5-3.5
Nilotex Carpet Care	2-6
Off Skintastic Insect Repellent for Kids	>90
Off! Deep Woods for Sportsmen Insect Repellent IV, Aerosol	50-60
Off! Deep Woods Insect Repellent V Spray, Unscented	50-60
Off! Skintastic IV	90-95
Old English Furniture Wipes	4-8
Oust Air Sanitizer, Outdoor Scent	60-70
Oust Bathroom Citrus Scent Fan .40 oz.	40-60
Oust Bathroom Outdoor Scent Fan	40-60
Palmolive Original Hand Dishwashing Liquid	4.3
Paul Mitchell Freeze & Shine Super Spray	>60
Paul Mitchell Freeze & Shine Super Spray (New)	<60
Paul Mitchell Soft Sculpting Spray Gel	<20
Pine Power Disinfectant Cleaner	<5.0
Purell Instant Hand Sanitizer	62
Purell Instant Hand Sanitizer Dry Hands Formula	62
Purell Instant Hand Sanitizer Packets	62
Purell Instant Hand Sanitizer with Aloe, Moisturizers & Vitamin E	62
Purell Instant Hand Sanitizer, Original	62

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Purell Kids Own Berry Blast	62
Radio Shack 951 Low Residue Soldering Paste Flux	73
Radio Shack Cleaner/Degreaser	27
Radio Shack Professional Tape Head Cleaner	15-20
Rain X Marine Windshield Treatment	70-95
Rain X The Invisible Windshield Wiper	86
Rain-X Anti-Fog	70-99
Rain-X Windshield Wax	70-95
Repel Hunters' Insect Repellent with Earth Scent, 55 Percent DEET	<45
Repel Insect Repellent Family Formula Spray Pump, 23 Percent DEET	44
Repel Insect Repellent Scented Family Formula Aerosol, 23 Percent DEET	48.3
Repel Insect Repellent Sportsmen Formula Spray Pump, 25 Percent DEET	55
Repel Insect Repellent Sportsmen Max Formula, 40 Percent DEET	43.7
Repel Lemon Eucalyptus Insect Repellent Lotion	<10
Repel Lemon Eucalyptus Insect Repellent Spray Lotion	<10
Soft Soap Hand Sanitizer - Gel	60-65
Spic and Span 10X Concentrate Disinfecting All Purpose Spray	12-25
Spic and Span Floor and Multi Surface Cleaner	0-5
Spray N Wash Laundry Stain Remover	2-3
Static Guard	70-72
Survivor Lemon Eucalyptus Insect Repellent Lotion	<10
TEN O SIX Medicated Deep Pore Cleanser	<15
Time Mist Air Freshener W/Odor Counteractant	15-25
Ultra Downy Liquid Fabric Softener	1-5
Valspar One & Only Interior/Exterior Multi Purpose Flat Black Finish	5-10
Valspar One & Only Multi Purpose Gloss Enamel, Almond	5-10
Valspar One & Only Multi Purpose Gray Metal Primer	5-10
Viadent Advanced Care Rinse	5-10
Wet Ones Antibacterial Moist Towelettes, Citrus	9.6
Wet Ones Antibacterial Moist Towelettes, Travel Pack, Citrus	9.6
Wet Ones Antibacterial Portable Washcloths, Ultra	0-9.6
Wet Ones Kids Antibacterial Wipes, Wild Watermelon & Ballistic Berry	0-9.6
Wet Ones Moist Towelettes with Aloe, Travel Pac	0-10.5
Wet Ones Moist Towelettes with Vitamin E & Aloe	0-10.5
Wet Ones Portable Washcloths with Vitamin E & Aloe, Ultra	0-10.5
Wet Ones Ultra Portable Antibacterial Wash Cloths	9.6
Wet Ones, Antibacterial Moist Towelettes, Thick Cloths	9.6
Zep Tile and Terrazzo Cleaner	5-15

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Ambenyl	cough suppressant	Forest	5
Ambenyl-D	expectorant, nasal decongestant, cough suppressant	Forest	9.5
Anesol	oral antiseptic, anesthetic	Whitehall	70
AsbronG Elixir	anti-asthmatic	Sandoz	15
Bayer children's Cough Syrup	cough suppressant, nasal decongestant	Glenbrook	5
Benadryl Decongestant Elixir	antihistamine	Parke-Davis	5
Benadryl Elixir	antihistamine	Parke-Davis	14
Benylin Cough Syrup	cough suppressant	Parke-Davis	5
Benylin DM	cough suppressant	Parke-Davis	5
Bronkolixir	bronchodilator, decongestant	Winthrop	19
Cepacol/Cepacol Mint	mouthwash, gargle	Lakeside	14.5
Ce-Vi-Sol	vitamin C drops (infant)	Mead-Johnson	5
Cheracol D	cough suppressant, decongestant	Upjohn	4.75
Cheracol Plus	cough suppressant, decongestant	Upjohn	8
Chlor-Trimeton Allergy Syrup	antihistamine	Schering	7
Choedyl Elixir	bronchodilator	Parke-Davis	20
Colace Syrup	laxative	Mead-Johnson	1
Colgate Mouthwash	mouthwash/gargle	Colgate-Palmolive	15.3
CONTAC Nighttime	antihistamine, analgesic, cough suppressant, decongestant	SmithKline	25
Dilaudid Cough Syrup	cough suppressant, analgesic	Knoll	5
Dimetane Elixir	antihistamine	A. H. Robins	3
Dimetane Decongestant Elixir	antihistamine, decongestant	A. H. Robins	2.3
Dimetapp Elixir	decongestant, antihistamine	A. H. Robins	2.3
Diural Oral Suspension	diuretic, antihypertensive	Merck Sharp & Dohme	0.5
Donnatal Elixir	anti-spasmodic	A. H. Robins	23
Elixophyllin-Kl Elixir	anti-asthmatic	Forest	10
Feosol Elixir	iron supplement	SmithKline	5
Fergon Elixir	iron supplement	Winthrop	7
Geriplex-FS	vitamins (geriatric)	Parke-Davis	18
Geritol Liquid	vitamins	Beecham	12
Geritonic Liquid	vitamins	Geriatric	20
Gevrabon	vitamins	Lederle	18
Hycotuss	expectorant	DuPont	10
I.L.XB12 Elixir	iron supplement	Kenwood	8
Iberet Liquid	vitamins	Abbott	1

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Imodium A-D	anti-diarrheal	McNeil	5.25
Incremin	vitamins	Lederle	0.75
Indocin Oral Suspension	analgesic	Merck Sharp & Dohme	1
Kaochlor S-F	potassium supplement	Adria	5
Kaon-CL 20%	potassium/chloride supplement	Adria	5
Kaon Elixir	potassium supplement	Adria	5
Kay Ciel Oral Solution	potassium supplement	Forest	4
Klorvess 10% Liquid	potassium/chloride supplement	Sandoz	0.75
Lanoxin Elixir Pediatric	cardiac medication	Burrougfhs Wellcome	10
Lasix Oral Solution	diuretic	Hoechst-roussel	11.5
Listerine Antiseptic	mouthwash/gargle	Warner-Lambert	26.9
Lomotil Liquid	anti-diarrheal	G. D. Searle & Co.	15
Lufyllin Elixir	bronchodilator	Wallace	20
Marax-DF Syrup	bronchodilator	Roerig	5
May-Vita Elixir	vitamins	Mayrand, Inc.	13
Mediatric Liquid	estrogen replacement	Wyeth-Ayerst	15
Mellaril Oral Solution	antipsychotic	Sandoz	3-4.2
Mestinon Syrup	treatment of myasthenia ravis	Roche	5
Naldecon DX Pediatric Drops	decongestant	Bristol	0.6
Nicotinex	niacin supplement	Fleming & Co.	14
Niferex Elixir	iron supplement	Center Labs	10
Novahistine Elixir	antihistamine, decongestant	Lakeside	5
Novahistine Expectorant	cough suppressant, decongestant, expectorant	Lakeside	7.5
Nucofed Expectorant	cough suppressant, decongestant, expectorant	Beecham	12.5
Nucofed Pediaric Expectorant	cough suppressant, expectorant, decongestant	Beecham	6
Nu-Iron Elixir	iron supplements	Mayrand, Inc.	10
Nystex Oral Suspension	antifungal antibiotic	Savage	1
Organidin Elixir	expectorant	Wallace	21.75
PBZ Elixir	antihistamine	Geigy	12
Pamelor Oral Solution	anti-depressant	Sandoz	3-5
Peri Colace Syrup	laxative	Mead-Johnson	10
Permitil Oral Concentrate	anti-psychotic	Schering	1
Phenergan Syrup Plain	antihistamine	Wyeth-Ayerst	7
Phenergan Syrup Fortis	antihistamine	Wyeth-Ayerst	1.5
Phenobarbital Elixir	sedative	Rosane	13.5
Polaramine Syrup	antihistamine	Schering	6

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Poly-Histine Elixir	cough suppressant	Bock	4
Prolixin Elixir	anti-psychotic	Princeton	14
Quelidrine Syrup	cough suppressant	Abbott	2
Robitussin	expectorant	A. H. Robins	3.5
Robitussin A-C	cough suppressant, expectorant	A. H. Robins	3.5
Robitussin CF	cough suppressant, decongestant, expectorant	A.H. Robins	3.5
Robitussin DAC	expectorant, decongestant, cough suppressant	A. H. Robins	1.9
Robitussin Night Relief	analgesic, cough suppressant, decongestant	A. H. Robbins	25
Robitussin PE	decongestant, expectorant	A. H. Robbins	1.4
Sandimmune	immunosuppressant	Sandoz	12.5
Scot-Tussin Sugar-Free Expectorant	expectorant	Scott-Tussin	3.5
Sominex Liquid	sleep aid	Beecham	10
Sudafed Cough Syrup	decongestant	Burroughs Wellcome	2.4
Tacaryl Syrup	antihistamine	Westwood	7.37
Tagamet Liquid	ulcer medication	Smith Kline & French	2.8
Tavist Syrup	antihistamine	Sandoz	5.5
Theo-Organidin Elixir	bronchodilator, expectorant	Wallace	15
Triaminic Expectorant	expectorant, decongestant	Sandoz	5.5
Tussar-2	cough suppressant	Rorer	5
Tussar SF	cough suppressant	Rorer	12
Tussend	cough suppressant	Lakeside	5
Tussend Expectorant	cough suppressant, decongestant, expectorant	Lakeside	12.5
Tylenol Adult Liquid Pain Reliever	analgesic	McNeil	7
Tylenol Cold Medication Liquid	analgesic, decongestant, cough suppressant, antihistamine	McNeil	7
Tylenol with Codeine Elixir	analgesic	McNeil	7
Vicks Daycare Liquid	decongestant, analgesic, expectorant, cough suppressant	Richardson-Vicks	10
Vicks Formula 44	cough suppressant, antihistamine	Richardson-Vicks	10
Vicks Formula 44D	cough suppressant, decongestant	Richardson-Vicks	10
Vicks Formula 44M	cough suppressant, decongestant, analgesic	Richardson-Vicks	20
Vicks Nyquil	decongestant, cough suppressant, antihistamine, analgesic	Richardson-Vicks	25

Products Containing Alcohol

Please note: Some prescription nasal sprays used for allergic rhinitis and some other forms of nasal/sinus congestion contain alcohol. Alcohol-containing nasal sprays that should be avoided by recovering persons, especially those taking Antabuse, include Flonase and Nasonex nasal sprays. The majority of mouthwashes contain alcohol also. These should all be avoided.

5% Alcohol (10-Proof)

Diphenhydramine Elixir
Benylin Cough Syrup
Cheracol-D Cough Syrup (guaifenesin/dextromethorphan)
Dihstine DH Elixir (chlorpheniramine/pseudoephedrine/codeine)
Dilaudid Cough Syrup (hydromorphone)
Dramamine Liquid (dimenhydrinate)
Feosol (iron) Elixir
Imodium A-D (loperamide)
Kaon Liquid (potassium)
Kay Ciel Liquid (potassium)
Guiatuss AC Syrup (guaifenesin/codeine)
Phenergan VC Syrup (promethazine/phenylephrine)
Tussend Syrup (guaifenesin/chlorpheniramine/pseudoephedrine/hydrocodone)
Tylenol Extra Strength Liquid
Tylenol with Codeine Elixir
Vicks 44 D (dextromethorphan/pseudoephedrine)
Vicks 44 E (guaifenesin/dextromethorphan)

10% Alcohol (20-Proof)

Excedrin PM Liquid (acetaminophen/diphenhydramine)
Geritol Tonic Liquid (multivitamin)
Hycotuss Expectorant Syrup (hydrocodone/guaifenesin)
Niferex Elixir (iron)
Nucofed Expectorant Syrup (guaifenesin/pseudoephedrine/codeine)
Nu-Iron Elixir (iron)
Vicks Nyquil (doxylamine/pseudoephedrine/dextromethorphan/acetaminophen)
Vicks Formula 44M (chlorpheniramine/pseudoephedrine/dextromethorphan/acetaminophen)

15% Alcohol (30-Proof)

Cepacol Mouthwash
Gerivite Elixir (multivitamin)
Lomotil Liquid (diphenoxylate/atropine)

20% Alcohol (40-Proof)

Gevrabon Liquid (vitamins)
Listerine Mouthwash (flavored)
Lufyllin Elixir (theophylline)
Theophylline Elixir

25% Alcohol (50-Proof)

Listerine Mouthwash (regular)
N'ice Throat Spray

This document was created by Talbott Recovery Campus. For more information, please visit www.talbottcampus.com.

Talbott Recovery Campus
5448 Yorktowne Drive
Atlanta, GA 30349

MONTANA PROFESSIONAL ASSISTANCE PROGRAM

SINCE 1995

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

Sexual misconduct
Certain types of legal involvement

FORMAL INTERVENTION OFFERED

Yes

ASSESSMENT

Provided 3 referrals

TESTING

Agency: RecoveryTrek
Frequency: 40 per year for first 2 years, 25 per year for years 3 and 4, 15 for year 5

REQUIRED MEETINGS

AA or alternative
peer support
PHP meeting quarterly for nurses and pharmacists

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Quarterly meetings for nurses and pharmacists; all participants engage in frequent phone contact

CHEMICAL RELAPSES

Required reassessment, and asked to stop working, reported to the Board

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Tiered response

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Case by case (with evaluation)
Buprenorphine: Case by case (work with prescriber)
Medical Marijuana: No
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Dentists
Residents
Podiatrists
Physician assistants
EMT/Paramedics
Nurses
Pharmacists
Other licenses under Board

LENGTH OF MONITORING

1 year for mild SUD, 5 years for moderate to severe SUD

APPROXIMATE FEES

$110-$172 depending on profession

SAFE HARBOR

Non-mandated: Yes, but not for nurses due to statute
Mandated: Yes, if compliant

STAFF

Michael Ramirez, M.S.,
Clinical Director

David G. Healow, M.D.,
Medical Director (part time)
2 Clinical Coordinators

FUNDING SOURCES

Participant fees
Special assessment on medical, nursing, dental, and pharmacy licensing fees

OF ACTIVE PARTICIPANTS

120
60%-65% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

91%

Table of Contents

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY FOR MEMBERS OF THE BOARD OF DIRECTORS WHO ARE CHEMICALLY DEPENDENT

As a matter of policy, the Montana Professional Assistance Program, Inc. recognizes the need for and encourages the participation of physicians, dentists, nurses and pharmacists who are recovering from chemical dependency, as active members of the Board of Directors of MPAP, Inc.

MPAP has an obligation to ensure that members of the Board who are chemically dependent are involved in the same types of recovery activities that are required of MPAP program participants, including chemical monitoring of at least six times per year, and signed aftercare contracts. If the Board Member has less than five (5) years of documented recovery, monitoring should occur according to the standard schedule.

Potential candidates for membership on the Board of Directors should have no less than three (3) years of documented continuous recovery and abstinence before being considered for membership on the Board.

All costs incurred for chemical monitoring will be borne by individual Board members.

Revised: 11/ 9/ 2017

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY ON COMMITMENT TO A DRUG FREE WORK ENVIRONMENT FOR MEMBERS OF THE BOARD OF DIRECTORS OF THE MONTANA PROFESSIONAL ASSISTANCE PROGRAM

Whereas the Montana Professional Assistance Program is dedicated to assisting licensed physicians, dentists, nurses and pharmacists with diseases possible impairment, including chemical dependency, the members of the Board of Directors acknowledge the need and importance of demonstrating and promoting the concept of a drug free professional work environment.

As such, members of the Board of Directors will voluntarily submit to a urine specimen collection each year, for the purpose of testing for alcohol and other mood altering drugs.

The specimen will be submitted at one of the regularly scheduled Board Meetings of the MPAP during the year. The specimen collection will be witnessed by a fellow Board Member.

All specimens will be sent to an appropriate laboratory facility for analysis. All laboratory costs incurred for testing will be paid for by the MPAP.

Any positive results which occur from testing will be verified by the Medical Director of MPAP and forwarded to the President of the Board of Directors of the MPAP for further consideration.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY ON MAINTENANCE OF RECORDS AND PATIENT CONFIDENTIALITY

The purpose of this policy is to insure that health care information obtained by the Montana Professional Assistance Program (Program) shall, except as provided by federal and state law, be confidential.

"Health care information" means any information, whether or not recorded, that identifies or can readily be associated with the identity of a patient and relates to the patient's health care. The term includes any records of the identity, diagnosis, prognosis, or treatment of any patient in connection with alcohol abuse or drug abuse.

"Health care" means any care, service or procedure provided by a health care provider, including diagnosis, treatment, evaluation, advice, referral, or other services that affect the structure or any function of the human body.

The Program's director, clinical coordinators and board of directors shall have access to the Program's health care information for the purpose of performing the functions, duties, and responsibilities of their respective positions.

The program may not disclose health care information to any person outside the Program, or disclose any information identifying a patient as an alcohol or drug abuser or identifying the patient as a person receiving services, or who has received services from the Program unless:

1. The patient consents in writing. The consent shall be on a form approved by the Program. A copy of this form is attached to this policy and designated Exhibit "A".

2. The disclosure is made to medical personnel to the extent necessary to meet a bonafide emergency.

3. The disclosure is made to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation. These will be subject to the restrictions disclosed by state or federal law.

4. The disclosure is allowed by court order. However, a court order authorizing disclosure does not compel a disclosure unless a subpoena or similar legal mandate is also issued to compel disclosure.

5. The disclosure is otherwise authorized by state law and not prohibited by federal law.

6. The disclosure is otherwise authorized by federal law. Unless authorized by a court order, health care information may not be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient. However, this policy does not prohibit the disclosure of any information about a crime committed by a patient either at the Program or against any person who works for the Program, or about any threat to commit such a crime. Nor does this policy prohibit the disclosure of any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The restrictions and limitations on disclosure and use of health care information contained in this policy apply to health care information concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

Each disclosure made by the Program with the patient's written consent must be accompanied by a notice disclosing the prohibition on re-disclosure. A form providing such notice and approved by the Program is attached to this Policy and designated Exhibit "B".

Except as prohibited by federal law, the Program shall report to the State Board of Medical Examiners, Dentistry, Nursing and Pharmacy any information it has which appears to show that a practitioner is:

1. Medically incompetent;

2. Mentally or physically unable to safely engage in the practice of medicine or dentistry; or

3. Guilty of unprofessional conduct as defined by 37-3-322, MCA.

If a program is ordered to make application to participate in the Program by a state licensing board, the Program shall require such person as a condition of participation to sign a written consent, authorizing disclosure of health care information to such state licensing board, and authorizing any contract between such person and the Program, or to comply with the conditions of participation, if any, in the Program, or with any recommendations made by the Program to such person.

At the time of admission to the program or as soon thereafter as the patient is capable of rational communication, all alcohol and/or drug abuse patients shall be provided a notice of the federal confidentiality requirements. A form providing such notice and approved by the program is attached to this policy and designated Exhibit "C".

It shall be the responsibility of the director of the Program to maintain a legible, up-to-date, and complete chart on each Program participant, including, but not limited to:

1. Pertinent referral and background information.

2. Differential diagnosis.

3. Summary of the intervention process and treatment referrals made to the patient.

4. A copy of the intervention and treatment contract.

5. A copy of the discharge summary from the treatment facility.

6. A copy of an after-care monitoring contract.

7. A record of all after care activities, such as attendance at self-help meetings and support groups, as well as urine monitoring test results.

8. A record of any advocacy activity performed on behalf of the Program participant with any state or local regulatory agencies or any state or local professional societies or hospital medical staff.

9. The record shall include a copy of all correspondence sent or received on behalf of each Program participant.

CONSENT TO DISCLOSURE OF HEALTH CARE INFORMATION

I, _____, birth date_____, hereby request and authorize the Montana Professional Assistance Program to disclose (kind and amount of information to be disclosed)

_____

_____

_____

To: (name and title of the person or organization to which the disclosure is to be made)

_____

_____

Purpose of disclosure:

_____

DATED this _____day of_____, 20____.

_____
Signature of Participant

_____
Signature of Witness

This consent is subject to revocation at any time except to the extent that the Program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (Specific date, event or condition)

_____

_____

NOTICE OF PROHIBITION ON REDISCLOSURE OF HEALTH CARE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This information is considered privileged and confidential in accordance with peer review statutes governing information from the Medical Assistance Program (Title 37, Chapter 2, Part 202, Montana Code Annotated). The proceedings and records of Medical Assistance Program relating to a licensee who has received or is receiving assistance from the Medical Assistance Program are confidential and are considered to be proceedings and records of a professional standards review committee under 37-2-201, MCA; and are not subject to discovery or introduction into evidence in any administrative or judicial proceeding other than a disciplinary proceeding against the licensee before the applicable licensing board. If the proceedings and records are introduced into evidence in a disciplinary proceeding, the introduced materials are public unless otherwise protected by law.

This information is also protected by Montana confidentiality laws in certain instances (Title 50, Chapter 16, Part 5). Montana law prohibits you from making any further disclosure of this information in certain instances. Should you require to make a further disclosure, you are to consult Title 50, Chapter 16, Part 5, Montana Code Annotated, to determine if further disclosure is allowed, and if so, to what extent.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

(1) The patient consents in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Reviewed: 2/17/2010

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY FOR REFERRAL OF PROGRAM PARTICIPANTS BY PROFESSIONAL LICENSING BOARDS, PROFESSIONAL PRACTICE SOCIETIES, AND/OR HOSPITAL DISCIPLINARY COMMITTEES

From time to time, program referrals will be made by the State Professional Licensing Board or other disciplinary agencies that have authority over the professional in question. Appropriate referral sources will include, but not be limited to:

A. Professional Licensing Boards

B. County or State Professional Associations

C. Hospital or Clinic Staffs or Administrators

D. State, County, or Local Agencies, such as the Judicial System, Social Welfare Departments, etc.

Referrals may be made by telephone contact, letter, or in person. The MPAP maintains an office in Billings with a phone line which is connected to a 24 hour answering service. All telephone or written referrals will be received by the Medical Director of the MPAP and will be followed up and handled promptly in a confidential manner.

Initial assessment will entail gathering all available written and verbal information regarding the circumstances surrounding the necessity that the referral has become the subject of any disciplinary hearing or proceedings or contemplated disciplinary action.

The Medical Director of the MPAP, or his official representative(s) will directly contact the individual(s) or agency who have filed a complaint or expressed concerns regarding the actions and/or behavior of the practitioner.

After obtaining all pertinent background information and medically assessing the facts, the Medical Director will:

A. Establish a differential working diagnosis

B. Plan and conduct an appropriate intervention

C. Make an appropriate treatment referral

D. Follow the client's treatment progress, and complete an after care monitoring contract with the program participant once he/she has completed treatment.

E. Monitor the recovery progress of the participant and make such reports as required by the Licensing Board, or hospital staff. (All program participants will be notified in advance when mandatory periodic progress reports are a requirement of the referral agency. In these cases appropriate release forms will be obtained from the participant).

The referral agency will be notified in the event that the practitioner:

A. Does not follow the recommendations for treatment referral.

B. Does not complete treatment.

C. Is not in compliance with the aftercare monitoring contract.

In addition, any impairment, behavior or activity that falls under the compulsory reporting requirements of the pertinent Montana statutes and rules, will be reported to the appropriate Professional Licensing Board.

The MPAP will continue to function in an advocacy role for all program participants whether mandated or not, as long as they are in compliance with all requirements of the program.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY ON VOLUNTARY/SELF-REFERRAL

As stated in the policy on the diseases of impairment covered by MPAP, the mission of the program is to provide early diagnosis and intervention, appropriate treatment referrals, and meaningful structured rehabilitation for the impaired practitioner before they become incompetent, develop serious or fatal physical disorders, and/or endanger the health and welfare of their patients. The philosophy of the program is that illness/impairment is not always synonymous with incompetence.

It is our hope that more and more, program participants will voluntarily enter the MPAP, whether by means of self-referral, or at the urging of professional colleagues, family or friends. In addition, the practitioner's patients can be a potential referral source. Concerned persons may report an individual to the program and MPAP will follow up to investigate available facts and contact the person in question to offer services as appropriate.

To this end, an important function of the MPAP is to inform the health care practitioners, and their families, and the public of the reason for the existence of the MPAP, and how the program can aid impaired healthcare professionals and their families.

The MPAP will fulfill this educational mission by making educational presentations on the "diseases of potential impairment" for state, county, local dental and medical and hospital professional organizations and auxiliary organizations. The MPAP will also serve as a public information source regarding diseases of impairment that can affect health care practitioners. Explanation of the function of the MPAP including diagnosis, intervention, treatment referral, after care monitoring, rehabilitation, advocacy, and family assistance is an important component of the educational program.

Confidentiality is stressed as one of the cornerstones of the program. The MPAP feels that practitioners, colleagues, family and friends are more apt to be successful in convincing an impaired practitioner to voluntarily seek help if there are no harsh punitive overtones, threat of public embarrassment, or threat to the practitioner's ability to continue his/her professional practice.

Notwithstanding the desire of the MPAP to extend confidential help and assistance to impaired practitioners, the program is bound by state statute to report to the Professional Licensing Board a practitioner who is (a) medically incompetent; (b) mentally or physically unable to safely engage in the practice of medicine; and (c) guilty of unprofessional conduct.

In addition, the MPAP reserves the right to report to the Professional licensing Board those individuals who (a) have a clearly definable problem and refuse to seek treatment; or (b) those individuals who have received treatment but fail to adhere to the

requirements of their aftercare monitoring contract. MPAP will report all major contract violations, either by the individuals assigned participant number or by formal complaint to the Board screening panel. The report will include referral and compliance history and current participant actions relative to the non-compliance along with a summary of MAP interventions for public protection.

Through educational presentations, practitioner's nurses, office staff, family, friends and/or patients will be made aware of the telephone number of the MPAP and the fact that a 24 hour CONFIDENTIAL answering service is available at this number. As calls are received, they are referred to the Medical Director of the MPAP. The Medical Director returns all calls promptly.

The Medical Director obtains such facts and information to determine the nature and scope of the problem. If necessary, the Medical Director will travel to the location of the impaired physician or dentist to make personal interviews and gather additional information.

Next, the Medical Director will arrange for and conduct an intervention when appropriate. Treatment referral will be made at the time of the intervention. If the practitioner refuses the option of treatment, the Medical Director will report to and confer with the Board of Directors of the MPAP to plan any further action.

Once a program participant is in treatment, his progress will be followed by the Medical Director. Upon completion of treatment, the Medical Director of the MPAP will construct an after care monitoring contract with the participant, defining his rehabilitation activities including random drug/alcohol screening.

The Medical Director of the MPAP will serve in an advocacy role for the program participants with various federal, state, and local agencies and/or hospital boards as long as they are in compliance with the stipulations of their aftercare monitoring contract. If a participant fails to meet the requirements of his/her after care contract, the Medical Director will report the situation to the Board of Directors of the MPAP to determine the future course of action.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

CRISIS INTERVENTION PROTOCOL POLICY

In the event that a situation occurs wherein immediate action must be taken to ensure safety to the public or safety to an individual physician, dentist, nurse or pharmacist the following protocol will be followed:

I. The Clinical Director of MPAP will be apprised of the situation and will then determine appropriate action.

II. If the Clinical Director is unavailable, a call will be placed to the President of MPAP's Board of Directors, who will then determine appropriate action.

III. If the President of the MPAP Board of Directors is unavailable, a call will be placed to a member of MPAP's board of directors. This person will then determine the appropriate action to be taken.

IV. If none of the aforementioned parties are available, the administrative assistant in consultation with the Legal Counsel of the accredited licensure board will then determine the appropriate action to be taken.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

MPAP POLICY ON TREATMENT CENTERS FOR MONTANA HEALTH PROFESSIONALS WITH CHEMICAL DEPENDENCY

Because of some special factors associated with Health Professionals with chemical dependency, it is recognized that there are some special considerations when it comes to selecting appropriate treatment centers for Chemical Dependency Treatment and Rehabilitation. Massive Denial and late-stage disease by the time of detection by others are some of the more important recognized factors in considering appropriate treatment referral sources for Montana Health Professionals.

With rare exception, it will be MPAP policy that Health Professionals be referred to facilities which have staff that are skilled and experienced in dealing with chemically dependent health professionals. All treatment placement recommendations will be approved by MPAP and based on clinical severity and national ASAM (American Society of Addiction Medicine) placement criterion. In addition, we feel that it is important that the facilities have a high percentage of Peer Health Professionals participation in the treatment process at any given time. Lastly, it is very important that the facility have the ability to provide extended treatment.

MPAP requires that appropriate treatment facilities demonstrate the ability to provide three phases of treatment:

Phase 1: Stabilization

Phase 2: Substance Abuse-Free Existence

Phase 3: Mirror Imaging

During Phase I, or stabilization, we recommend a minimum of four weeks of Residential Treatment or eight weeks of Intensive Outpatient Treatment.

During Phase 2, or substance abuse-free existence, the facility will provide "Feelings Group" experience and individual counseling. Strong Second Step-Spirituality is very important at this point. Also, the facility needs to provide an appropriate therapeutic residence where the Health Professional can gain Group Living Skills, work on the Family Dynamic Issues and achieve integration into the local community AA 12-Step Program. This phase will last for four (4) to eight (8) weeks.

During Phase 3, or the mirror imaging phase, it is important that the facility allow the Health Professional to interface with incoming addicts and alcoholics to enable him to become more aware of the denial associated with chemical dependency. It is important at this stage that the facility continue working with Spirituality Issues, in particular fourth (4th) and fifth (5th) Step Issues. Appropriate Therapeutic Residence continues to be

very important whereby the Health Professional gains further Group Living Skills, works on Family Dynamic Issues and integrates more solidly into the AA Community. It is extremely important that the facility provide a Family Program and Family Education about addictive disease.

Any request for departure from policy regarding approved treatment facilities will be considered by the Medical Director of MPAP and/or the Board of Directors of MPAP in consultation with the Regional Coordinator or Chairman of the local hospital committee on Professional Health and Well Being.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY FOR DETERMINING THE NEED FOR EXTENDED TREATMENT FOR CHEMICAL DEPENDENCY

It is the philosophy of MPAP, that with rare exception, Montana Health Professionals will benefit from Extended Chemical Dependency Treatment; that is, treatment that extends beyond the usual twenty-eight (28) day community inpatient or outpatient stay for chemical dependency. Following are some of the criteria which are useful in determining the need for extended treatment:

I. Use of highly rewarding drugs:
Intravenous use of opiates, cocaine, amphetamines or any other euphoria producing drugs.

II. Lack of strong support base:
Uncooperative family or deterioration of other significant relationships.

III. Inability to remain abstinent, despite apparently adequate initial treatment.
1. History of multiple relapses coupled with inadequate motivation for sobriety.
2. Lack of sober support system.

IV. Advanced physical disease, secondary to chemical dependence.
1. Cognitive deficits as a result of chemical dependency.
2. Physical disease such as chronic pancreatitis, cirrhosis of the liver, etc.

V. Co-existing psychiatric illness affecting recovery; such as:
1. Character style reflecting severe personality disorder.
2. Affective disorder.
3. Chronic psychotic disorders.
4. Organic brain disorder (other than alcohol).
5. High risk of potentially successful suicide.

VI. Monitoring/follow up issues:
1. Geographic isolation
2. History of poor follow up or compliance.
3. Severe legal problems

VII. Lack of progress in Phase I or stabilization treatment phase:

In general, the need for extended treatment will be determined by the Medical Director of MPAP in consultation with the Medical Director or Attending Physician of the Chemical Dependency Treatment Facility, ideally around the third week of Phase I or stabilization treatment.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY ON RELAPSE MANAGEMENT

MPAP recognizes that chemical relapse is inherent in the disease of chemical dependency. Further, MPAP recognizes that relapse can be a positive re-enforcement tool in rehabilitation if recognized early and managed properly. MPAP does recognize that there are some relapse situations which are more serious and require more urgent drastic action.

It is MPAP policy that all chemical use is to be reported to the Professional Assistance Program.

RELAPSE MANAGEMENT

Level 1: Relapse behavior without chemical use; this will be reviewed by the group therapist or facilitator with no further action.

Level 2: Persistent relapse behavior without chemical use which is not changing; this will be reviewed by the Montana Professional Assistance Program Medical Director, the Regional Coordinator, the Professional Monitor, and the group therapist or facilitator, who will make recommendations which may include individual counseling or return to more intense treatment.

Level 3: Relapse into chemical use; this will require review by the Montana Professional Assistance Program clinical director, the Medical Director, the assigned professional monitor and the group therapist or facilitator, and the situation will be brought to the attention of the Montana Professional Assistance Program board of directors for review.

Level 4: Relapse into persistent chemical use and refusal of additional treatment; this will be reviewed by the board of directors of the Montana Professional Assistance Program and reported to the Professional Licensure Board.

Level 5: Relapse in the context of practice impairment; this will be reported immediately to the Professional Licensure Board.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

POLICY ON CHEMICAL MONITORING

Toxicology Screening is conducted for all program participants with a history of substance abuse or dependence, whose clinical history suggests verified abstinence may be warranted to alleviate exacerbation of other symptomatology, or as recommended by the evaluation or treatment team. The goals of toxicology testing are deterrence and detection.

Participants with abstinence requirements stipulated in their MPAP continuing care agreement are prohibited from ingestion or use of a non-prescribed mood-altering substance that could compromise their recovery status and result in a relapse into addictive thinking or behavior, and result in noncompliance with the terms of monitoring and possible sanction. Utilizing current toxicology methodologies, including forensic, chain-of-custody protocol and truly random screening procedures, test panels, screening and confirmation thresholds are sufficiently sensitive and specific to detect recent or remote ingestion of substances commonly abused by recovering health professionals.

Verified abstinence through random toxicology screening helps to promote long-term, favorable outcomes by increasing the likelihood of success, while reducing the frequency of relapse. Toxicology results serve as a data set upon which to provide a basis for advocacy to authorized third parties. Similarly, forensic defensible results help to protect the public safety in the event of a confirmed positive test result.

MPAP uses a flexible testing schedule combined with targeting testing that is determined by clinical history, drug history, and adherence with monitoring requirements. Participants generally are assigned to one or more color groups on initial presentation based upon clinical profile. Frequency and type of testing may be adjusted on the basis of performance in monitoring.

A participant may be assigned to one or more of the following color groups (with corresponding frequency and type of testing):

PINK	60 per calendar year	Urine	Year 1
PURPLE	40 per calendar year	Urine	Years 1-2
RED	57 per calendar year	Oral Fluid	Year 1
+BROWN	2 per calendar year	Urine	
+BLACK	1 per calendar year	Urine	
YELLOW	37 per calendar year	Oral Fluid	Years 1-2
+BROWN	2 per calendar year	Urine	
+BLACK	1 per calendar year	Urine	

AQUA	22 per calendar year	Urine	Year 3
+BROWN	2 per calendar year	Urine	
+BLACK	1 per calendar year	Urine	
AQUA	22 per calendar year	Oral Fluid	Year 3
+BROWN	2 per calendar year	Urine	
+BLACK	1 per calendar year	Urine	
BLUE	14 per calendar year	Oral Fluid	Year 4
+BLACK	1 per calendar year	Urine	
GREEN	7 per calendar year	Oral Fluid	Year 5
+BLACK	1 per calendar year	Urine	
ORANGE	5 per calendar year	Oral Fluid	Year 5+
+BLACK	1 per calendar year	Urine	

Determination of the color group or groups to which a participant is assigned is a clinical decision made on the basis of global assessment of recovery, adherence to monitoring, third party reports, attitudinal and behavioral measures, and stability in recovery.

The Medical Director is responsible for assuring that the laboratory being used for testing is appropriately qualified and certified. The Medical Director has the authority to deem which laboratories are appropriate to fulfill the toxicology screening services required by the MPAP.

In selected cases, additional types of screening procedures including blood analysis, breath-analysis, and/or hair analysis may be utilized for monitoring purposes to ensure compliance by program participants in their aftercare rehabilitation programs.

All laboratory fees incurred in toxicology testing are the responsibility of the program participants.

TESTING PROTOCOL

1. Physician, dentist and pharmacy participants are required to log on to the MPAP website and follow the link to the testing web page or to call the designated 800 number daily between the hours of 0500 and 1300 while nursing particpants have from 0500 to 1700. Please reference your MPAP Participant Number when responding to e-mail or voice mail prompts.

2. Voluntary “5 Plus” participants shall be notified by MPAP staff on the day in which they are scheduled to be tested. Alternative arrangements may permit daily check-in, as above. All other testing requirements shall otherwise apply.

3. If the color group to which a participant is assigned is designated, the participant has SIX (06) hours in which to present for observed collection from the time that the participant checks the website or calls the 800 number.

4. The sample must be collected under direct observation to ensure that the sample is not adulterated in any way. For urine collection, the specimen must be observed urethra to cup. With prior MPAP approval, alternative "dry-room" testing may be used as a reasonable accommodation for participants with legitimate, documented medical reasons.

5. Collectors are considered members of the peer monitoring network and must be approved by MPAP in advance. Criteria for selection of collectors are discussed below.

6. In the rare case of exigent circumstances in which a currently approved primary, secondary, or tertiary collector is unavailable (e.g., travel, vacation), and a non-designated collector must be used, the participant is responsible for contacting MPAP staff via telephone or voice mail immediately with the identity of the collector, then providing the MRO copy of the drug testing custody and control form on the next business day for follow-up with the collector, as necessary. Please assure that the collector's name, address, and telephone number are clearly legible on the form provided to MPAP.

7. Failure to check the web page or to call the 800 number or to present for observed collection on the required day within the SIX (06) hour window shall be considered a "positive test result."

8. In the event that a participant is planning to travel outside her or his work or residence area or to otherwise be unavailable, they are required to notify MPAP by completing the travel planning form that is linked to this web page in advance of anticipated travel dates. Participants shall be required to continue to check in daily, and to present for collection if the color group to which they are assigned comes up for testing while they are away, unless advance permission to deviate from the protocol is obtained from MPAP Staff. Determination regarding authorized deviation from the protocol is a clinical decision made on a case-by-case basis.

9. Please utilize the designated MPAP Participant Number ONLY, not your name or social security number, when completing the drug testing custody and control form.

10. The designated collector, NOT his or her staff, should witness the collection, complete and sign the drug testing custody and control form.

11. Requisition forms must be filled out COMPLETELY. All kit seals must be initialed by the collector or the donor, and placed on the seam of the appropriate container to assure that the chain-of custody value of the specimen remains intact. The long, narrow seal goes over the specimen container. Insert the original requisition inside the

sleeve of the outer container (plastic bag) before attaching the outer seal. In the event that a collector other than those approved in advance by MPAP is used, a copy of the original requisition should be faxed to the MPAP office on or before the next business day. The donor retains the designated copy of the requisition. Remember to include the collector's address on the shipping box.

12. The collector is responsible for retaining custody of the specimen until it is transferred to the post office for delivery.

13. Urine or oral fluid test kits and requisition forms should be ordered through the MPAP office. Please do not order excessive quantities.

14. Further questions should be directed to MPAP Staff.

CRITERIA FOR VOLUNTEER RANDOM DRUG TEST COLLECTORS

The following guidelines are suggested for selection of random drug test collectors for the purposes of professional oversight and monitoring by the Montana Professional Assistance Program:

1. Ideally, the collector should be a licensed healthcare professional, preferably a peer;

2. Same-sex collector for observed urine collection;

3. Disinterested third-party;

4. Willing to adhere to the protocol;

5. Available within the specified period;

6. Participants must declare all pre-existing relationships with prospective collectors to avoid potential conflicts of interest;

7. No family member collectors;

8. No current MPAP participants who themselves are subject to random toxicology testing;

9. Exceptions to the above criteria shall be evaluated by MPAP on a case-by-case basis.

Revised: 11 / 9 / 2017 Reviewed:

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

EMPLOYMENT POLICY

GENERAL PROVISIONS

Job Descriptions and employment policies for MPAP (Corporation) are not contractual and are subject to change by the Board of Directors from time to time. However, changes in a job description or an employment policy do not effect rights and duties that matured, penalties that were incurred, or proceedings that were begun before the effective date of a change in the job description or employment policy.

Any changes in a job description or employment policies will be presented to the employee in writing and discussed with the employee in advance of their implementation.

TERMINATION OF EMPLOYMENT BY EMPLOYEE

In the event that an employee elects to terminate employment, 30 (thirty) days notice is requested in writing.

DISCIPLINE AND DISCHARGE

1. A. It is the policy of the Corporation that employees who fail to perform job duties in a satisfactory manner; whose conduct disrupts the Corporation's operations; or who violate an established procedure, policy, rule or regulation be subject to disciplinary action up to and including discharge.

B. Discipline shall be commensurate with the seriousness of the offense. For example, the Corporation, at its option, may utilize informal counseling or an oral or written warning for routine performance deficiencies and lesser offenses. Whereas, more severe disciplinary action including discharge will be taken for more serious offenses and repeated lesser offenses.

C. "Discharge" means the termination of an employee's employment, and includes constructive discharge as defined in 39-2-903, MCA.

D. "Good cause" means reasonable, job-related grounds for discharge based on failure to satisfactorily perform job duties, disruption of the Corporation's operations, or other legitimate business reason.

Good cause includes, but is not limited to, an actual violation of an established Corporation standard, legitimate order, policy, or agreement, failure to meet applicable professional standard or a series of lesser violations. It al includes:

(1) Breach of patient confidentiality;

(2) Misappropriation of corporate funds or property;

(3) Incompetence;

(4) Unexplained or excessive absence from work; a written note from a physician must verify any request for sick leave beyond 48 hours;

(5) Chronic tardiness;

(6) Failure to carry out assigned tasks as delineated in the job description.

(7) Reduction in force, lay off for lack of work, or elimination of the job.

2. During the first 180 days of employment, the employee is on probationary status and may be discharged at any time without cause or prior notice. In the event of such termination, employee will be entitled to two weeks severance pay.

3. All employees, who have completed the probationary period, may be discharged at any time but only for good cause. Employees may be discharged for good cause without prior notice. In all cases of discharge. The reasons shall be set forth in writing by the president or person designated by the president within ten days of discharge if the employee so requests.

4. In the event that employee is terminated on any of the grounds set forth in Section 1.D.(7), employee will be entitled to two weeks severance pay.

NOTICE OF PROCEDURE FOR APPEAL OF DISCHARGE

The Corporation shall within seven days of the date of discharge notify the discharged employee of the appeals procedures under the following section, and provide the discharged employee with a copy of the procedure for appeal of discharge.

PROCEDURE FOR APPEAL OF DISCHARGE

1. A. An employee who has been discharged may appeal the decision to discharge. The appeal shall be in writing and state the reasons why the employee believes he should not be discharged. The appeal shall be submitted to the Clinical Coordinator, Medical Director or president of the Corporation within 20 days of the date of discharge. The Corporation shall respond to the appeal in writing within 15 days, and mail or deliver a copy of the response to the discharged employee. The discharged employee may then submit a written reply to the Corporation's response and deliver it to the Corporation within 10 days of receipt of the Corporation's response to his appeal.

B. The Board of Directors of the Corporation shall appoint one person or three persons to hear and decide the appeal. Those persons may include board members, employees, and/or non-employees of the Corporation. This person or persons are hereinafter referred to as the Adjudicator. If three persons

are appointed, the decision of a majority shall be the decision of the Adjudicator.

C. Copies of the discharged employee's written appeal, the Corporation's response, and the discharged employee's reply shall be submitted to the Adjudicator. The Corporation shall direct the Adjudicator to either render a decision based solely upon the employee's written appeal, the Corporation's response, and the employee's written reply thereto, or to hold a hearing before rendering a decision. If directed, the Adjudicator shall hold a hearing, at which the adjudicator shall accept oral testimony and other evidence from the discharged employee and the Corporation. After hearing, the Adjudicator may affirm the discharge, or the Adjudicator may substitute other disciplinary action for the discharge, including, but not limited to, a demotion, a suspension without pay, a reprimand or any combination of such actions. If the Adjudicator does not find cause for discharge, it shall reinstate the employee. The Adjudicator shall hold such hearing and render its decision within 90 days of the date the written appeal of the discharge is received by the Corporation.

PROCEDURE FOR APPEAL OF OTHER DISCIPLINARY ACTION

1. All disciplinary action other than discharge may be appealed as follows:

   (1) An Employee who has been disciplined (but not discharged) may appeal the decision to discipline. The appeal must be in writing and state the reasons why the employee believes he should not be disciplined or that he should be less severely disciplined. The appeal shall be submitted to the Clinical Coordinator, Medical Director or president of the Corporation within seven days of the date the employee is notified of the decision to discipline. The Corporation shall respond to the appeal in writing within seven days, and mail or deliver a copy of the response to the disciplined employee. The disciplined employee may then submit a written reply to the Corporation's response and deliver it to the Corporation within 5 days of receipt of the Corporation's response to his appeal.

   (2) The Board of Directors of the Corporation shall appoint one person to adjudicate the appeal. Unless the disciplinary action involves a loss of compensation, the Adjudicator's decision shall be based solely upon the employee's written appeal, the Corporation's response and the employee's written reply thereto. If the proposed disciplinary action involves a loss of compensation, then the Corporation may, in its discretion, direct the Adjudicator to hold a hearing before rendering a decision.

HEARINGS PROCEDURE

1. Hearings held under this policy shall be informal and be presided over and controlled by the Adjudicator.

ANNUAL REVIEW OF JOB PERFORMANCE

1. The job performance of all employees will be reviewed on an annual basis. The review of the Medical Director and Clinical Coordinator will be performed by the board of directors or a person or committee designated by the board of directors. The review of all other employees will be performed by the Clinical Coordinator in consultation with the Medical Director. A written copy of the review will be provided to the employee to which the employee may add written comments. The employee shall sign the review and return it to the person or persons performing the review and it shall be retained in the employee's personnel file.

Approved: 9/20/2002 Reviewed:

Montana Professional Assistance Program, Inc.
Gift Policy (DRAFT)

The **Montana Professional Assistance Program, Inc. (MPAP)** is a charitable 501(c)(3) non-profit organization duly constituted under the laws of the State of Montana and recognized by the Internal Revenue Service. As such, MPAP accepts gifts and moneys donated by the public in furtherance of its stated professional tax-exempt mission and activities.

MPAP is administered by a duly appointed Board of Directors which is responsible for gift acceptance matters.

Gift Definition – Any contribution of cash, bequests, equipment, stocks, property, retirement or life insurance beneficiary designations, tangible personal property, charitable remainder or charitable lead trusts, or in-kind services shall be considered a gift.

Cash is acceptable in any form including credit card donations made online via our website or newsletter.

Acceptance Authority

The President, Medical Director, or Clinical Director of MPAP has authority to accept all standard cash, equipment and in-kind services on behalf of the organization. Less utilized opportunities for donation such as stock, property or planned gifts will be considered by the Board of Directors to ensure the gift is in the best interest of MPAP and to determine the best interest of MPAP in terms of immediate sell verse investment. Most commonly, such gifts will be redeemed via immediate sell. The MPAP Board of Directors has the ultimate authority to accept or reject any gift on behalf of MPAP.

Policy

The MPAP Board of Directors and its staff solicit current and deferred gifts from individuals, corporations, insurance carriers, professional associations, foundations, etc. to secure the growth and further the goals of MPAP in it charitable mission**.** This policy governs the acceptance of gifts by MPAP and may provide guidance to prospective donors and their advisors when making gifts to MPAP. Notwithstanding, any donor should consult with their own attorney and CPA in determining the financial advisability of donations. The provision of these policies shall apply to all gifts received by MPAP for any of its program operations or services.

MPAP will accept gifts and money from the public in furtherance of its mission and consistent with its stated purpose as defined within its bylaws, respective memoranda of understanding, mission statement and goals statement. MPAP, in soliciting or accepting gifts, shall clearly represent the organization's policies and mission which might pertain to this exchange and honor all statements about the use of the contribution. MPAP shall always disclose to potential donors important and relevant information. Every gift will be promptly acknowledged by IRS compliant receipt.

Specific requests about acknowledgment will be honored consistent with MPAP's practices and policies. MPAP reserves the right to refuse a gift if it is determined to be in conflict with the organizations mission. Considerations include, but are not limited to:

1) Contributions may be designated for a specific program activity or project if the donor requests and such designation does not prove impossible to meet or the gift may – in most cases – be used to meet MPAP's most pressing priorities. Planned gifts may not mature for many years; therefore MPAP must be aware of and document a donor's intentions for future implementation. The MPAP Board of Directors must either expressly approve any donor restrictions or decline to accept the gift.

2) MPAP may determine it is not advisable to assume any indebtedness in connection with a gift. Such gifts are considered for approval on a case-by-case basis by the Board of Directors.

3) Contributions must support and enhance the mission and purpose of MPAP. Contributions which subject the organization to burdensome or unusual restrictions will not be accepted.

4) Associated expenses with the conveyance of a gift made to MPAP are to be borne by the donor unless prior arrangements are made by MPAP.

5) MPAP will assume that donors rely on their own personal advisors for tax, legal, financial and other advice concerning their gifts.

6) If gifts of cash are to be designated to a specific program or activity, it should be clearly stated both on the check and in a cover letter or e-mail to MPAP and so acknowledged on the receipt.

7) MPAP will accept gifts of equipment/furniture that are determined to be of use to the organization. The Clinical Director may make that determination.

8) MPAP will accept gifts of tickets or air miles for travel to be used by staff or board members to attend conferences/meetings related to the organizations mission and goals.

9) MPAP may accept gifts of publicly traded securities, including stocks, mutual funds, municipal and corporate bonds, and treasury bills and notes. The MPAP Board of Directors shall determine the instruments sale or investment.

10) MPAP may accept gifts of real estate. The MPAP Board of Directors shall determine the properties sale or investment. If property is encumbered by indebtedness, the donor will be required to provide for payment of carrying costs until the property is liquidated.

11) MPAP may accept contributions of art antiques, jewelry, automobiles, etc. after obtaining appraisal or documentation of fair market value before the gift is accepted. The MPAP Board of Directors shall determine the properties sale or investment.

12) MPAP may accept gifts of insurance such as life insurance products. The donor would receive a tax deduction for the replacement cost of the paid up policy at the time of donation (not the face value of the life insurance). The donor may elect to continue paying premium payments and thereby obtain a tax deduction for each payment if it is done in the following manner: gift the policy to MPAP, who then becomes the owner of the policy. The donor then makes annual donations in the amount of the annual premium costs to MPAP, who then pays the policy. The donor then receives a tax deduction for every contribution for the premium payment. Donors may also purchase a new policy, naming MPAP as the beneficiary. The premiums and tax benefits would work exactly as listed above.

Legal and CPA Counsel

Legal and CPA counsel may be employed when needed for advice on any proposed gift or to review any proposed transaction for possible conflict of interest. MPAP may seek the advice of counsel particularly where it concerns gifts of securities, those involving contracts, documents naming MPAP as the Trustee, gifts involving contracts, real estate, art, insurance products and any transaction with potential conflict of interest.

Declining Gifts

MPAP's Board of Directors may decline any gift that in its collective judgment creates unacceptable challenges, undue expense, or a perception of impropriety or conflict with the organization's mission.

Standards of Practice

MPAP staff who work in planned giving will adhere to the American Council on Gift Annuities Model Standards of Practice for Charitable Gift Planner available at www.acga-web.org.

Donor Acknowledgement

Contemporaneous receipts for all gifts, regardless of amount, will be prepared in accordance with IRS requirements indicating as is best ascertainable by the MPAP, the gift date, amount of cash given or description of property received, and for any goods or services given in exchange for the gift. If no goods or services were received by the donor, the receipt will include a statement to that effect.

MPAP will not place a value on what is donated, but rather provide a statement of what was donated. Exceptions to providing a value statement to donors include a) gifts of property over $5000 and any vehicle donated. Gifts of property over $5000 and any vehicle donated requires an appraisal and the donor may be provided with a value.

For individual gifts or groups of related gifts valued at $5000 or more, which are not cash or marketable securities, MPAP will sign an acknowledgement of receipt of the gift on the Internal Revenue Services Form 8283.

MPAP will not state that a contribution is deductible – contributions may be deductible, based on the donor's particular tax situation and it is the donor's responsibility to determine deductibility with their CPA/Tax Attorney.

MPAP will maintain a master list of all gifts.

When questions exist regarding any donation, MPAP will consult with appropriate CPA and/or legal counsel.

Confidentiality of Donor

All information concerning donors and prospective donors shall be held in strict confidence by MPAP, subject to legally authorized and enforceable requests for information by government agencies and courts. MPAP will not disclose the amount of any gift through any publication or other public document without the permission of the donor, except as required by the IRS.

Conflicts of Interests

MPAP will not accept any gift if it represents a conflict of interest or gives the appearance of a conflict of interest.

MPAP shall accept no gifts from active program participants under monitoring contracts or from their immediate family, business associates or friends.

The MPAP staff, Board of Directors, Committee Members and Volunteers are expressly forbidden from accepting personal gifts from active MPAP Program Participants, their family members, business associates or friends.

Approved:

Montana Professional Assistance Program, Inc.
Ethics Policy

1. Rationale / background for policy:

The general principles informing this section are that the Montana Professional Assistance Program, Inc. officers, board members and staff should be objective and fair to program referrals and participants in MPAP program; they should avoid potential, actual or perceived conflicts of interest, whether financial, professional or personal; and they should not accrue personal gain from their involvement with MPAP; and they should maintain appropriate boundaries from MPAP referrals and participants.

2. Policy Statement:

For purposes of this Policy, the term “Covered Individuals” means all MPAP officers, directors, members and chairs of committees, or other decision-making group members and chairs. "Covered Individuals" includes all MPAP staff and consultants retained by MPAP. The "Gifts" section of this Policy shall also apply to all MPAP staff, regardless of position.

Covered Individuals bring to the MPAP expertise drawn from their diverse knowledge and backgrounds, which may, at times, conflict with the interests and activities of the MPAP. Covered Individuals are obliged to act in the best interest of the MPAP and to place the achievement of the MPAP’s goals and mission above their other interests. In general, where any conflict of interest may exist, the best approach is for the Covered Individual to identify it, disclose it, and record it in the minutes (including action taken upon the conflict.)

MPAP values its Covered Individuals’ different viewpoints and expertise, and encourages full and open discussion in its decision-making process. At times, the contributions of an individual with a personal interest are valuable precisely because of the knowledge or expertise obtained through an outside interest. Accordingly, full participation by Covered Individuals should be encouraged, and limitations shall be placed on their activities only in those cases where they cannot separate the outside interest from the interest of the MPAP and render a fair and independent decision. In those cases, the Covered Individual should recuse himself or herself from discussion and vote on the issue.

3. Procedures:

A. Potential, Actual, or Perceived Conflicts of Interest and Recusals

An actual conflict of interest may arise if a Covered Individual has a material financial interest in business before the MPAP, or where an MPAP action could affect the Covered Individual's professional status.

i. Material Financial Interest

Covered Individuals shall disclose their ownership of a material financial interest in any entity which furnishes goods or services, or is seeking to furnish goods or services, to the MPAP. The disclosure requirement of this section shall also apply to material financial interests owned by immediate family members of covered individuals.

The MPAP recognizes that individuals may have investments, through stock ownership, mutual funds, and similar vehicles, in companies that provide goods and services to businesses. Only those investments that constitute a significant financial investment raise a concern about a possible conflict of interest. The MPAP also recognizes that covered individuals may be employed by, or have a consulting arrangement with, an organization that does business with the MPAP. A conflict of interest may arise if the covered individuals hold a key position in such company and is responsible for approving the provision of goods or services to the MPAP. Accordingly, a "material financial interest" shall mean holding a financial ownership of 5% or more, or holding a position as proprietor, director, managing partner or key employee.

Covered individuals shall recuse themselves from discussion and vote on any issues relating to the provision of the goods and services by any company in which a covered individual or any immediate family member owns a material financial interest.

ii. Professional Interest

By law, the majority of MPAP members are professionals who are involved in the oversight of members of their own profession. MPAP's work may require members to make decisions or take positions which adversely or positively affect a referral's or participant's professional status. If such an action would confer a professional benefit to a Covered Individual (for example, by taking a competitor out of the marketplace, or by leaving a colleague in practice), that person shall identify the conflict, and recuse him or herself from discussion and vote.

iii. Close personal or professional relationship

A Covered Individual shall recuse him or herself from any MPAP discussion or vote concerning anyone with whom the Covered Individual has a close personal or professional relationship. This would include anyone in a sponsor-sponsee relationship or practice partner of the Covered Individual. Mere acquaintance of the referral or participant does not disqualify a Covered Individual.

iv. Maintaining Appropriate Boundaries with MPAP Clients in Recovery Meetings

Given the unique nature of the recovery process and the anonymity of mutual self-help recovery meetings, an MPAP Covered Individual may find him or herself at a meeting at which an MPAP client is present. Although the Covered Individual's first obligation is to stay well and in recovery, the Covered Individual should exercise caution in interacting with MPAP clients in this way. The staff member should discuss this situation with his or her manager to ensure that appropriate boundaries are maintained.

v. Social Networking

In order to maintain professional and confidential relationships with MPAP participants, MPAP staff members and Consultants are generally discouraged from doing any of the following:

1. Searching for any past, present, or reasonably known potential future participant on any social networking sites (including Facebook, Twitter, Linked In, Pinterest, Instagram, etc.);
2. Sending a request to "friend" or "follow" any past, present, or reasonably known potential future participant on any social networking site; or
3. Accepting a request to "friend" or "follow" any past, present, or reasonably known potential future participant on any social networking site. If a participant sends such a request, discuss this with your manager to determine the most appropriate way to respond.

Past MPAP participants have sometimes assumed new roles within MPAP after monitoring is concluded, such as being named to the Board of Directors. Therefore, there may be instances where it would be appropriate for MPAP staff or consultants to engage in social networking contact with such individuals. These situations should be reviewed in advance with other MPAP staff and/or members of the Board of Directors.

MPAP staff members and consultants are strongly encouraged to:

1. Review at regular intervals their privacy and security settings on their social networking sites, to ensure that these settings provide an appropriate level of privacy and confidentiality; and
2. To maintain any presence on a social networking site that is professionally appropriate and will reflect well on MPAP if viewed by participants or others.

If an MPAP staff member or consultant has a pre-existing social network relationship with a participant (prior to employment or contracting), that individual will be discouraged from having any direct contact with the participant as part of their duties with MPAP. Further, the staff member must discuss this with his or her manager to ensure that appropriate boundaries are maintained.

vii. Participation in Other Organizations

Participation by Covered Individuals in the activities of other organizations is beneficial to the MPAP, as these individuals gain important expertise and establish business relationships. To avoid conflicts of interest, Covered Individuals shall disclose their participation in other organizations where a potential for conflict exists. If the overall goals and objectives of the MPAP and the other organization do not conflict, participation is permitted. If a conflict exists, Covered Individuals shall choose between the conflicting organizations and shall resign from one position.

viii. Potential or apparent conflicts of interest

If a Covered Individual has an interest in another relationship or organization which actually prevents that person from being objective, he or she should disclose this to the Chair, and recuse himself from discussion or vote.

A more subtle situation arises where the Covered Individual believes that he or she can be objective, but an outsider might perceive a conflict of interest. This could arise from a personal, professional, or recovery relationship with the referral or participant, and could be perceived to provide either benefit or harm to the referral or participant. The standard should be whether a reasonable, independent third person would think the Covered Individual could be objective. To preserve the integrity of MPAP decisions, if there is any question, the Covered Individual should disclose the relationship and recuse himself.

If the Covered Individual does not appropriately excuse himself or herself, but the majority of the remaining directors believe that he or she should be recused, the Chair shall require that person to recuse himself or herself from discussion and vote.

B. Gifts

Covered Individuals shall not solicit or accept for personal benefit directly or indirectly any gift, loan, or any item from an MPAP client (either an active participant, referral or reasonably known potential clients) or from an assessment or treatment center to which MPAP clients may be referred, or any other entity with whom the MPAP does business, with whom the MPAP is seeking to do business, or from any entity seeking to do business with the MPAP. A prohibited gift shall be declined, returned, paid for at fair market value, or donated to a charity.

The following are exceptions to the gift ban:

i. Covered Individuals may attend a meeting, educational program or social event hosted by a professional group or entity.

ii. Covered Individuals, may also receive books, journals, audio or videotapes, computer software or other informational material provided to assist them in performing their duties for the MPAP.

iii. A Covered Individual may partake of refreshments, meals, and entertainment made available to all attendees at professional meetings. However, if a Covered Individual attends a gathering hosted by a professional group or entity, MPAP should endeavor to reimburse that entity for the cost of the food and amenities provided.

iv. Items of nominal value (under $25) given in normal business practice and which would not raise an inference of undue influence may be accepted. Such items would include a paperweight, commemorative plaque, or coffee mug given for speaking at a professional meeting.

v. Gifts made for a non-business reason, and which are motivated by a family relationship or personal friendship, may be accepted.

vi. Benefits or discounts which are offered as a professional courtesy to members of the medical profession, or to members of their immediate family, provided such benefits or discounts are not intended to influence a MPAP decision, may be accepted.

C. Honoraria

Any honoraria received by covered individuals for MPAP-related engagements shall be given to the MPAP.

D. Illegal Payments

A Covered Individual shall not give any bribe, kickback, or any other illegal or improper payment of any kind to any person with whom the Covered Individual comes into contact in the course of carrying out his or her responsibilities for the MPAP.

E. Disclosure of Confidential or Proprietary Information

In the course of performing services to the MPAP, Covered Individuals will have access to information that is confidential or proprietary to the MPAP. This information includes, but is not limited to, financial information, business plans, policy proposals and recommendations, policy development plans, confidential participant information, and other information which would impede implementation of MPAP activities and potentially harm referrals and participants if disclosed. Covered individuals shall maintain the confidentiality of such information and shall not disclose confidential or proprietary information. Covered individuals shall use his or her best efforts to prevent unauthorized disclosure of confidential or proprietary information.

F. Use of Position or MPAP's Name

Covered Individuals shall not use the MPAP name or their affiliation with the MPAP for commercial gain. Covered individuals shall not use the MPAP's name, or his or her affiliation with the MPAP in a manner that would incorrectly imply a MPAP endorsement of a non-MPAP service, or that would imply MPAP support of a personal opinion or activity.

G. Activities Following Term

Former Covered Individuals shall not use the MPAP name or their affiliation with the MPAP in any manner which would imply MPAP support or endorsement of policies or activities of another organization. Former Covered Individuals shall not use the MPAP

name or their affiliation with the MPAP for commercial gain. Former Covered Individuals shall refrain from all conduct, verbal or otherwise, which publicly disparages or damages the reputation, goodwill, or standing in the community of the MPAP or other covered individuals.

Approved:

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

COMMUNITY REINTEGRATION AND RETURN TO PRACTICE POLICY

This policy is to provide guidelines in assisting and advocating a participants' re-entry into the healthcare field and surrounding community. Readiness for return to work is based on over-all stability and an individual's risk profile indicating there is no eminent risk for public safety. Reintegration is considered case-by-case and is contingent on completion of any stipulations of the respective Board.

Such guidelines are intended as a means to help MPAP continue to monitor the participant's compliance in their agreement surrounding the re-entry phase and process. MPAP will consider advocacy for the participant returning to work based on monitoring compliance and clinical presentation. MPAP will make a clinical judgment according to the previous two conditions as a means to determine if the participant can safely practice within their profession. MPAP will use the following factors for review in developing a consensus for the participant's return to work:

-Previous history of clinical severity and individual's capacity.

-Primary provider/Counselor recommendations.

-Completion of primary treatment.

-Recent work history.

-Established supervision and drug-testing is in place.

The terms and conditions for re-entry are informed, as above, and determined clinically by MPAP on a case-by-case basis.

The following are practice guidelines included within the aftercare agreements for **Nurses and Pharmacist** designed as base requirements for a participant to follow when returning to practice, under their respected license:

i. The participant will agree to not seek or accept any employment or any other professional relationship for their respective practice without the prior approval from MPAP.

   The Participant will not return to professional employment, on a full-time or part-time basis, until and unless the Participant's Primary Treating Professional's prognosis for continued recovery is good and that Participant is capable of practicing nursing with reasonable safety to patients. Participant must have approval from MPAP and all employment required processes must be completed prior to returning to work. Before accepting or engaging in professional employment of any kind, whether as an employee or independent contractor and whether on a full-time or part-time basis, the Participant will enter into an

agreement with each and any such employer or contractor, in the form and substance prescribed by MPAP and incorporated in the program. The employer's agreement must be completed and returned to the MPAP office prior to beginning work. Failure to obtain prior approval from MPAP constitutes a violation of the Continuing Care agreement and will result in the automatic suspension of participant's license for a minimum of six (6) months.

ii. Nurses participating in the MPAP will not work in the following areas without prior approval from MPAP:

-Traveling Position

-Float Pool

-Temporary Employment Agency Work

-Home Based Setting

iii. Nurses participating in the MPAP will agree to the following conditions:

-Shall not work more than 80 hours in any 2 (two) week period;

-Shall not work shifts within 12 hours of each other;

-Shall not work more than 3 (three) 12 hours shifts in a four day period;

-Shall not accept a supervisory position;

-Shall not work for more than one employer;

-Shall abide by all policies, procedures, and contracts of employer;

-Shall ONLY work for a supervisor who has signed and returned the *Supervisor Instruction and Agreement Form* and who has been given a copy of the MPAP contract;

-Shall notify the MPAP office immediately of any change in supervisors.

Exceptions to the above will be considered on an individual basis by MAP staff.

Other applicable practice limitations are based upon diagnosis, drug history, practice issues, and compliance history with MPAP. Additional limitations are considered on a case-by-case basis. Other restrictions may include, but are not limited to:

-Narcotic administration restriction for a specified period of time.

-Receiving direct supervision and review of narcotics records.

-Monitored Naltrexone, Suboxone, or Antibuse when working for a recommended period of time.

-No supervisory positions for a specified period of time.

-Inability to return to work until a specified period of compliance has been sustained.

Recovery Monitor – Quarterly Status Report

Return to OHPP by mail or fax

To: Medical Director / OHPP Compliance Manager
Oklahoma Health Providers Program
313 Northeast 50th Street
Oklahoma City, Oklahoma 73105
405-601-2536 (office) 405-605-0394 (fax)
ohpp@okmed.org (email)

Re: _____
Name of OHPP Participant

Date: _____

In my position as "Recovery Monitor" for the above named OHPP participant, the following statements represent my honest opinion (circle appropriate answer – please amplify on any "NO" answer):

1. YES NO Attendance at recovery group meetings is appropriate in number and participation.

2. YES NO Behavior indicates a continuing change consistent with adequate recovery efforts.

3. YES NO To my knowledge, his/her family is supporting his/her recovery efforts.

4. YES NO To my knowledge, no (new) legal issues have surfaced. ("YES" = no new issues)

5. YES NO To my knowledge, he/she has been compliant with their OHPP Recovery Agreement.

6. YES NO He/she states that random urine testing is being performed and the specimen collection is always observed by lab personnel.

If you would like to speak with the Medical Director or Compliance Manager about any additional concerns you have regarding the above OHPP participant, please indicate by marking an "X" in the checkbox, otherwise leave checkbox blank: ☐ Enter phone number below and preferred day and time to call if you checked box.

Phone: _____ Day of Week and Time: _____

Signed,

_____
Typed Recovery Monitor Name/Signature Above

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

GUIDELINES ON CONDITIONS OF POSSIBLE IMPAIRMENT

The stated purpose of the Montana Professional Assistance Program, Inc., hereafter known as the MPAP, is to address the problem of the ill physician, dentist, nurse, pharmacist or other health care professional whose ability to practice may be impaired due to a substance use disorder, psychiatric illness, physical condition or problems associated with aging. The MPAP, as such, does not offer treatment; rather it identifies relevant resources, makes appropriate referrals for professional evaluations and/or treatment, and monitors ongoing recovery and adherence to treatment.

The MPAP functions by providing advocacy and assistance to health care professionals and their families who are experiencing difficulties in living in a healthy and effective manner. In addition to the usual situations that can cause possible professional impairment, it is recognized that dysfunction within a professional's family can result in a marked decrease in the ability of a professional to safely and effectively practice.

The mission of the program is to provide early identification, effective intervention, referral for appropriate evaluation and treatment, and meaningful structured rehabilitation for the affected practitioner and their family members. Health care professionals involved in the program are hereafter referred to as "program referrals" and/or "program participants."

The objectives of the program are to (1) safeguard the health and welfare of the public, and, (2) help and restore to optimal professional functioning, wherever possible, professionals who are or may become impaired due to illness or chronic physical or mental condition that may impede their ability to practice their professional with reasonable skill and safety.

The program functions in an advocacy role for program referrals and participants, contingent upon their satisfactory compliance with recommendations for evaluation, treatment and monitoring, working in cooperation with, but independently from, state regulatory agencies such as the State Boards of Medical Examiners, Dentistry, Nursing and Pharmacy as well as professional associations at the State and local levels.

Ideally, affected practitioners can be helped through early identification and effective treatment and rehabilitation rather than face legal sanction or removal from practice by state regulatory agencies. Ideally, program participants and their families will feel encouraged to seek help early during the course of their illness rather than await overt practice impairment or actual patient harm.

The MPAP also may function in an advocacy and assistance role to individuals with a late stage disease who are mandated for treatment by their professional licensing board. In these cases, too, the MPAP will continue to function in an advocacy role promoting treatment and rehabilitation whenever possible rather than punitive measures alone.

The program is bound by statute to report a practitioner who is (a) medically incompetent; (b) mentally or physically unable to safely engage in the practice of medicine, dentistry, nursing, or pharmacy; and (c) guilty of unprofessional conduct. In addition, the program has a duty to report to the Board those individuals who (a) have a clearly definable problem and refuse to seek treatment; or (b) those who have received treatment but who fail to adhere to after care monitoring contracts.

The MPAP, as such, does not deal directly with professional competency issues arising from situations that are not related to illness or injury due to a substance use disorder, mental illness, or physical disabilities and problems associated with aging. The MPAP may, however, serve as a consultation resource for stakeholders in such instances.

The MPAP has a commitment to promote the health and wellness of health care professionals through ongoing educational efforts and publicity within the professional community and in the public media. The MPAP recognizes that family members of current and past program participants play a key role in educating spouses and other family members regarding the merits of the program and encouraging program referrals from family members.

Revised: 11/ 9 / 2017

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

GUIDELINES ON PERSONAL SAFETY OF REFERRALS

The purpose of these guidelines is to suggest procedures to provide every possible assurance for the personal safety of healthcare professionals immediately following an intervention.

In many instances, the insular environment which surrounds healthcare professionals, as well as the nature of addiction which is characterized by denial at many levels, have contributed to enable practitioner impairment to continue to the extent that social supports may be at or near the point of exhaustion. The situation may be presented wherein the practitioner has very limited individual, social, and professional resources upon which to rely and from which to gain emotional support and encouragement when faced with the crucial personal decision to accept or to refuse help.

Added to this dilemma may present a practitioner's propensity to seek external remedy, or to become isolated to the point that he or she becomes a danger to him or herself or others.

Particular attention should be paid to reliable reports or documentation which suggests a history of suicidal or homicidal ideation or gesticulation. In these instances, every effort should be made to provide for the personal safety of the referral to include the following contingency measures:

1) Arrange for a psychiatrist or psychotherapist to participate as a member of the intervention team, whenever possible.

2) Assess through structured interview the degree to which the referral may present an immediate and serious threat to him or herself or others.

3) Whenever possible, arrange for a trusted family member, personal friend, or colleague to attend and to participate in the intervention to help establish a therapeutic environment for the referral before the intervention has concluded.

4) Make necessary travel arrangements prior to an intervention, and schedule the intervention no more than four hours prior to scheduled departure.

5) Assure that a trusted member of the intervention team accompanies the referral from the intervention site, at all times until he or she has departed via scheduled transportation to the approved destination for evaluation.

6) Arrange prior to or immediately after the intervention for the referral to be met at the approved destination for evaluation by a representative of the evaluation facility, whenever possible.

7) In particularly difficult or questionable cases, a trusted member of the intervention team should accompany the referral to the approved destination for evaluation. If necessary and appropriate, the costs associated with this safety measure may be absorbed by MPAP, Inc., on a case-by-case basis.

For cases in which it is determined that the practitioner represents an immediate and serious threat to him or herself or others, the process of involuntary commitment to an appropriate psychiatric facility to assure the public safety should be initiated through the support of a licensed psychiatrist who has been familiarized thoroughly with the situation. As a contingency, the necessary arrangements for involuntary commitment should be made in advance, and implemented on the advice of the psychiatrist, with the understanding that the practitioner's liberty must be restored as soon as his or her personal safety and the public safety can be assured, with reasonable certainty.

REVIEWED: 11 / 9/ 2017

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

GUIDELINES FOR CONTINUING CARE AND MONITORING OF CHEMICALLY DEPENDENT HEALTH CARE PROFESSIONALS

1. Upon return from Chemical Dependency Treatment, MPAP Program Participants and their spouse or significant other will meet with the Medical Director of MPAP or one of his or her official representatives to determine that he/she has satisfactorily completed prescribed treatment and does not pose a risk to him/herself or others by resuming his/her professional activities, and discuss the essential elements of ongoing rehabilitation and monitoring.

2. The Program Participants will complete and sign an Aftercare Agreement with MPAP prior to resuming professional activities.

3. Program Participants are required to attend three (3) to four (4) 12-step self-help meetings per week such as AA or NA. Also, all participants are required to attend a Professional Support Group (Caduceus Club or Nightingale) Meeting twice a month. Attendance at Caduceus Meetings counts as attendance of a 12-step meeting. Program Participants are required to document attendance at all such meetings by submitting a monthly record of meeting attendance through Recovery Trek, MPAP's third party administration system. The log is to be reviewed by the Professional Monitor on a monthly basis.

4. If the Program Participant lives beyond a 100 mile driving radius or driving time in excess of 1 1/2 hours is required to reach the Caduceus Meeting, the Participant is only required to attend two (2) such meetings a month.

5. Beyond a 150 mile driving radius or 3 hour driving time, the requirement drops to one (1) Caduceus Meeting per month and may be excused from the quarterly meeting that may fall during the relevant period.

6. In the event of any planned absence, illness, or weather related absence, the Program Participant is required to notify the MPAP of his/her anticipated absence from the Caduceus Meeting.

7. Regardless of initial diagnosis all clients will engage in a period of professional therapy, determined by MPAP and Treating Professional, to at minimum address identified risk factors that may influence his/or her recovery and/ or their participation in the program. Group Therapy with a Psychiatrist, Psychologist, or Certified Chemical Dependency Counselor, knowledgeable in the area of Addictive Diseases and the 12-Step Recovery Process is the optimal format for Therapy. Individual Therapy can be considered on a case-by-case basis.

8. The group therapist, facilitator, or individual counselor must be approved in advance by MPAP.

9. Program Participants are responsible for all costs of Continuing Care Therapy and must make individual financial arrangements with their therapist or counselor.

10. The Therapist or Counselor will be required to keep progress notes and an overall treatment plan and provide a quarterly progress report, electronically through Recovery Trek, to MPAP.

11. MPAP will determine appropriate completion of all recommended treatment in conjunction with recommendations of the individuals' primary treatment provider Recommendations for either a decrease or increase in therapeutic aftercare and/ or any further appropriate treatment will be made at that time. It is anticipated that most Participants will be directed into Co-Dependency Therapy during their third year of rehabilitation

12. Urine, blood, or other body fluid monitoring will be an integral part of the Aftercare and Monitoring process. The specifics of drug testing are detailed in the MPAP Policy entitled "Policy on Chemical Monitoring."

13. Each Program Participant will be required to have an AA or NA sponsor. This individual will be identified as a party to the Aftercare Agreement, and as such, can report to or be queried by MPAP or other parties to the Agreement, regarding the Participant's progress. The Participant is required to meet with his/her sponsor on a weekly basis.

14. Each Program Participant will have a Professional Monitor. The description and duties of the Professional Monitor are detailed in the MPAP Policy entitled "Monitoring Professionals for MPAP."

15. The Program Participant will meet with the Professional Monitor on a monthly basis to discuss his/her overall progress with respect to personal and professional recovery. The Professional Monitor will communicate with other listed parties of the Agreement as needed to assist him/her in making an objective assessment of the Program Participant.

16. MPAP encourages Family Treatment as a part of the overall rehabilitation of the chemically dependent Health Care Professional. Program Participants are encouraged to work with their spouses or significant other to form their own support groups.

17. Participant Continuing Care Agreements will be reviewed by MPAP on an annual basis.

18. Continuing Care Agreements will typically run for a period of five (5) years, however; MPAP may elect to extend or shorten the effective duration of an Agreement on a case by case basis.

19. MPAP recommends that Program Participants continue with random drug screening even after the completion of the five year monitoring period. Ongoing screening would be done at a reduced frequency.

20. MPAP recognizes that relapse is a recognized possibility, even when Program Participants are involved in appropriate Continuing Care Therapy and Monitoring. The goal of the MPAP Program is to detect and respond to relapse in a timely and therapeutic fashion.

21. If the Program Participant is not known to the Board of Medical, Dental, Nursing or Pharmacy and agrees to and complies with all recommendations made by MPAP (including withdrawal from practice if necessary for further evaluation), then the Program Participant will not be made known to the Board by Name, however; his/her participation in the Program will be reported by a code number known only to MPAP and the Participant. If the Participant does not follow Treatment recommendations or is otherwise non-compliant, MPAP reserves the right to turn the Participant's files over to the Licensing Board for their consideration.

22. If the Program Participant is already known to the Licensing Board, MPAP will be required to notify the Board in the event of a Relapse and will make reports to the Licensing Board as they may require, using the Participant's name as well as his/her code number. Still, MPAP will continue to serve the Participant in an advocacy role for the Participant, recommending Treatment and other necessary Therapeutic Measures rather than punitive measures, so long as the Program Participant is cooperative with all treatment recommendations.

23. All listed guidelines are subject to review and may be modified from time to time as deemed appropriate by the Board of Directors of the Montana Professional Assistance Program, Inc.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

GUIDELINES FOR THE MANAGEMENT OF

POSSIBLE PSYCHIATRIC IMPAIRMENT

Approximately 30% of all referrals received by MPAP are referred for problems other than primary substance use disorders. About 60% of all participants whom are evaluated and/or receive treatment following multi-disciplinary assessment are diagnosed with a concurrent psychiatric illness in addition to a primary substance use disorder, while approximately 15% of all participants are diagnosed with problematic personality features or a personality disorder.

Healthcare professionals referred for consultation, evaluation and or/treatment present with symptomatology that is difficult to differentiate without thorough assessment. The etiology of a referred professional's maladaptive or dysfunctional behavior in the work setting frequently cannot be discerned without a comprehensive, multidisciplinary evaluation.

Identification of potential impairment due to possible psychiatric illness differs little from identification of possible impairment due to a substance use disorder.

Careful documentation of reported concerns is important. Interviews or statements based on first-hand observations with community collaterals including colleagues, auxiliary staff and, if possible, family members, are helpful. Colleagues may be as willing to reveal a practitioner's possible impairment from concern for potential liability as much as from collegial concern. It should be understood that statutory legal immunity through the Medical Practice Act of Montana includes investigations by medical peer review committees that are related to drug and alcohol abuse or mental or physical illness. Thus, practitioners on a medical peer review committee are protected from potential civil liability in the event of future litigation for good faith reporting.

The initial intervention process is very similar to that which is employed with a possible substance use disorder. Compassionate but firm confrontation of the affected practitioner is necessary to assure privacy while reflecting accurately reported concerns, and providing the option of participation in the diversionary track of participation in the MPAP versus reporting concerns directly to the respective licensure board. Identification of potential intervention team members should include at least one colleague who is trusted by the identified practitioner, a representative or leader of the parent institution, whenever possible, and a family member, provided that none of the members of the intervention team may sabotage the goals of therapeutic intervention.

Contingency planning for personal safety of program referrals should be addressed as a regular part of the intervention process, according to terms outlined in the MPAP Guidelines for the Personal Safety of Program Referrals.

Comprehensive multi-disciplinary assessment according to the standard of care contained in Criteria for Evaluation and Treatment of Montana Physicians, Section 24-156-429, Administrative Rules of Montana should be followed in most cases. The practitioner should be requested to withdraw from practice voluntarily in order to curtail compulsory reporting according to statutory reporting requirements.

Failure to comply with a reasonable request for evaluation should be handled in the same manner as a suspected substance use disorder. If a continuing or potential threat to public safety appears to exist, the affected practitioner must be reported directly to the Professional Licensing Board and the health care entity, if known, in which the practitioner has clinical privileges.

Montana Professional Assistance Program, Inc.
Guidelines for the Monitoring of Disruptive Behavior Cases

The following are levels of criteria that discriminate between monitoring eligibility verse non-eligibility:

1. **Eligible for MPAP Monitoring:** Disruptive Behavior cases (meeting the definition contained in the Statement of Protocol for Addressing Disruptive Behavior adopted as amended by the Montana Board of Medical Examiners) for which Montana Professional Assistance Program (MPAP) monitoring is advisable for contracted assistance and advocacy. If, on the basis of a formal evaluation provided by an MPAP-approved evaluator, all of the following conditions have been satisfied:

    a) Axis I clinical disorder and/or developmental disorder is present (necessary condition)
    b) For which active treatment and/or behavioral modification methods and/or reasonable accommodations are available in order to stabilize and manage symptoms and/or to remediate/compensate for behavioral/knowledge/social skill deficits
    c) Psychiatric and psychotherapeutic treatment and/or behavioral modification and/or educational remediation can reasonably be expected to result in improvement to the point where the individual can perform duties to an expectable standard of effectiveness and professionalism required of a fit healthcare provider.
    d) Provider-patient is willing to participate in active treatment and/or education/remediation
    e) Individual is willing to authorize MPAP to communicate with all medical and mental health professionals providing care or training for the purpose of evaluating progress and providing advocacy
    f) Individual is willing to actively and in good faith engage in therapeutic and educational interventions to ameliorate symptoms of illness and to remediate and modify professional behaviors and attitudes while on duty
    g) Individual is willing to learn and implement identified/newly learned behavioral strategies for modifying professional behaviors and attitudes in the active process of performing the duties of a licensed healthcare professional according to the standard of care, the statutes and regulations of the State of Montana, and any relevant/applicable institutional By-Laws regarding Professional Behavior

2. **Not Eligible for MPAP Monitoring:** Disruptive Behavior cases for which Montana Professional Assistance Program (MPAP) Monitoring is not advisable but for which it can be consulted regarding possible avenues for resolution/remediation. If, on the basis of a formal evaluation provided by an

MPAP-approved evaluator, one or more of the following conditions has been found to be met:

a) ***No*** Axis I clinical disorder and/or developmental disorder is present (necessary condition)
b) Individual is unwilling to participate in or collaborate with active efforts at treatment/remediation of an Axis I clinical/developmental disorder
c) Axis II personality traits or disorder(s) are the primary source of the disruptiveness in behavior, communications, and/or attitude
d) Interpersonal dynamics (i.e. involving not only the identified healthcare professional) within a given setting/team/practice group/organization are identified as the primary source(s) for disruption
e) Political processes form the primary basis for allegations of disruptiveness

Approved: September 2, 2011

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.
GUIDELINE ON LEGAL COUNSEL INVOLVMENT
IN CLINICAL DECISION-MAKING

The Montana Professional Assistance Program, Inc. acknowledges and supports the right of any program referral or participant to seek legal counsel at any point during their involvement with the Professional Assistance Program. In our experience, legal counsel may prove instrumental in helping to assure adherence to MPAP recommendations for evaluation, treatment, or aftercare monitoring requirements, which are developed based upon the medical model and issued in accordance with statuary guidelines. As a matter of policy, MPAP shall refrain from negotiating with legal counsel the terms of any reasonable request for evaluation of possible impairment, recommended treatment, or aftercare monitoring requirement. These matters are considered in the interest of public safety and the rehabilitation of licensed healthcare professionals with conditions of possible impairment; they are statutorily defined, contractually driven, and policy based. MPAP shall refer matters in which legal counsel for a program participant or referral insists upon negotiating or interjecting an adversarial position into the clinical decision making process of requested evaluation, recommended treatment, or aftercare monitoring requirements to the assigned Professional Licensing Board for consideration and legal consultation, as necessary and appropriate.

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

THE MONITORING PROFESSIONAL

The policy of MPAP, Inc. is to use monitoring professionals to assist chemically dependent and/or emotionally distressed health care professionals with re-entry into their community and practice and to monitor their compliance with the requirements of their continuing care agreement and progress in recovery to enable MPAP to serve in an advocacy capacity for the participants.

Ideally, the monitoring professional will be a physician, dentist, nurse or pharmacist who has a minimum of two (2) years of abstinence in recovery from chemical dependency, or one who has experience and strength in recovery from an emotional or mental illness. Ideally, this person would also be a member of the local hospital committee on physician or professional impairment. Because this type of personnel is not widely available in Montana, it will also be acceptable that the monitoring professional be a licensed Physician, Dentist, Clinical Psychologist, or licensed certified Chemical Dependency Counselor who has knowledge and experience in the field of chemical dependency and professional impairment.

The role of the monitoring professional will be to meet with the program participant on at least a monthly basis. During this meeting the monitoring professional will ascertain the following:

1. That the professional is regularly attending 12-step meetings and/or counseling sessions.

2. That the participant is regularly attending professional support group meetings.

3. That the participant is engaged in any other activities that are set forth in his recovery and continuing care agreement.

4. The monitoring professional will also ascertain as to whether or not the participant is progressing and performing satisfactorily in his professional practice and his personal and family life.

To accomplish this evaluation, the monitoring professional will have a copy of the continuing care agreement. The monitoring professional will be an identified and listed as a party to the continuing care agreement. As such, the monitoring professional will have the ability and authority to contact other parties listed on the continuing care contract to determine that the participant is in fact doing satisfactorily.

If the monitoring professional has any reason to feel that the program participant is not progressing satisfactorily or is not in compliance with his or her continuing care agreement, or is in danger of or in fact has relapsed, he will notify the Clinical Coordinator or Medical Director of MPAP immediately.

In order to obtain objective documentation of compliance with recovery activities, it will be the policy of MPAP that the monitoring professional will request a written documentation from the participant to verify attendance at 12-step recovery meetings.

Montana Professional Assistance Program, Inc.
Conflict of Interest Disclosure Statement

Please initial in the space at the end of Item A OR initial and complete Item B, whichever is appropriate. DO NOT COMPLETE BOTH. Complete Item C, and sign and date the statement.

A. I am not aware of any relationship or interest or situation involving my family or myself which might result in, or give the appearance of being, a conflict of interest between such family member or me and the Montana Professional Assistance Program, Inc.

_____ *Initials*

B. The following are relationships, interests or situations involving me or a member of my family which I consider might result in or appear to be an actual, apparent or potential conflict of interest between such family members or myself and the Montana Professional Assistance Program, Inc..

— (*Attach additional sheets if necessary*.) **DO NOT COMPLETE IF SECTION A WAS INITIALED**.

For-profit corporate directorships, positions or employment:

_____

Nonprofit trusteeships or positions:

_____

Memberships in the following organizations:

_____

Contracts, business activities and investments with or in the following organizations:

_____

Other benefits, arrangements, relationships, activities, etc.:

_____

My primary business or occupation at this time is:

_____

C. This Conflict of Interest Disclosure Statement and information contained herein shall be confidential and shall be used by the Montana Professional Assistance Program, Inc. only to the extent necessary to address actual, apparent, or potential conflicts of interest.

I will promptly inform the Montana Professional Assistance Program, Inc. in writing of any material change that develops in the information requested or contained in the foregoing statement.

_____	_____	_____
Type or print name	Signature	Date

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.
BOARD OF DIRECTORS
JOB DESCRIPTION

A board of up to 15 Directors governs the MPAP. Board membership is drawn from the constituency of the professional populations served. At least 30% of board membership must be from the general constituency, specifically not recovering from a condition of impairment. If recovering from addiction, Directors must have a minimum of three years of uninterrupted sobriety. Board appointments must be approved by a majority of Directors. Board appointments are for three-year terms. Board members may serve no more than two consecutive three-year appointments. Former Directors may seek reappointment after a period of at least three years off the board.

Directors must have an interest in the rehabilitation of licensed health care professionals in the State of Montana, a strong commitment to the mission of the MPAP, time, and energy to give to the organization for board meetings and other participation.

The Board bears overall responsibility for the direction and oversight of the organization as set forth in the Mission Statement, the Vision Statement, and the Strategic Plan and as carried forward by staff. The Board also is responsible for the financial health of the organization.

Besides interest, commitment, and time, Directors must bring some of the following specific skills and attributes to the organization:

- Geographic diversity;
- Experience in community or professional organizations, fundraising, financial management, communications, marketing, or administration;
- Knowledge of relevant issues and community concerns;
- Leadership and communication skills and a willingness to apply them to the governance of the organization, and;
- Diversity in age, gender, and race.

Attendance at board meetings is one of the primary obligations of Directors. The board meets three to four times annually. An annual Board retreat for strategic planning also is held in conjunction with one of the quarterly meetings. Quarterly meetings typically are held in Billings. Reimbursement for Directors' meeting related mileage expense is provided upon request. Directors are expected to attend board meetings – failure to attend two board meetings during a calendar year may result in dismissal.

The Board of Directors functions in part through a system of committees and Directors must be willing to lead or participate in committee work, which occurs during the course of board meetings and throughout the year. Current committees include Case Review. Other committees are created and filled by a majority vote of Directors.

Adopted: July 2004 Revised: June 2018

NC PHP

NC PHYSICIANS HEALTH PROGRAM

SINCE 1988

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

None

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: RecoveryTrek
Frequency: 3 to 4 times per month for first 18 months, then once per month; last year is quarterly

REQUIRED MEETINGS

Four abstinent based self-help meetings per month for first year, then 3 thereafter

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Random visit from Field Coordinators once a month in first three years

CHEMICAL RELAPSES

Require reassessment and asked to stop working

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Case by case basis

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary (may not practice)
Buprenorphine: Case by case basis (may not practice, taper required)
Medical Marijuana: N/A
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Residents
Physician assistants
Veterinarians
Registered Veterinary Technicians
Perfusionists
Clinical pharmacist practitioners
Anesthesiology assistants

LENGTH OF MONITORING

1 to 2 years for mild SUD, 5 years for moderate to severe SUD

APPROXIMATE FEES

$5-$250 depending on profession

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Updates to Board every two months

STAFF

Joseph Jordan, Ph.D., CEO
Clark Gaither, MD, FAAFP, Medical Director

1 Director, Program Operations
1 Assistant Director
1 Senior Field Coordinator
3 Field Coordinators
1 Clinical Coordinator
1 Senior Case Manager
1 Communications and Case Manager

FUNDING SOURCES

Professional organizations
Hospital contributions
Private contributions
Professional boards
Participant fees
Licensing fees

OF ACTIVE PARTICIPANTS

286
40% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

75%-85%

SEVERAL ITEMS WERE SHARED WITH THE REQUST THAT THEY NOT BE DISTRIBUTED

TMF
TENNESSEE MEDICAL FOUNDATION

SINCE 1978

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

Sexual misconduct
Medical issues causing impairment

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: Spectrum
Frequency: Weekly for first year, then every other week, gradually adjusted as necessary

REQUIRED MEETINGS

Three meetings (of some kind) per week
Caduceus meetings

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Quarterly during first 2 years, then twice a year thereafter
Meetings are via videoconference

CHEMICAL RELAPSES

Level system

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Level system

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary, (may not practice)
Buprenorphine: Case by case basis (with evaluation) Medical Marijuana: N/A
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Families of physicians
Medical students
Residents
Physician Assistants
Optometrists
Podiatrists
Veterinarians
Chiropractors
X-Ray Technicians

LENGTH OF MONITORING

Based on recommendations in assessment; when not specified, monitoring is typically 5 years

APPROXIMATE FEES

Non-mandated: $140
Mandated: Free

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Board requires quarterly report

STAFF

Michael Baron, MD, MPH, Medical Director

1 Administrator
1 Field Coordinator
1 Development Coordinator

FUNDING SOURCES

Malpractice insurance companies
Hospital contributions
Private contributions
Participant fees
Grants from state of Tennessee and other health related foundations

OF ACTIVE PARTICIPANTS

220
43% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

Higher than national average

Table of Contents

TENNESSEE MEDICAL FOUNDATION CONFIDENTIAL AUTHORIZATION AND CONSENT FORM INFORMATION PRIVACY POLICY

PRIVACY POLICY: The Tennessee Medical Foundation ("TMF") protects as confidential and privileged information it generates on physician participants in its Physician's Health Program ("PHP"). The TMF-PHP is intended to be a "Quality Improvement Committee" as defined in T.C.A. § 63-1-150 and T.C.A. § 68-11-272. Any and all actions of the TMF and the TMF PHP are intended to come within the provisions and protections of T.C.A. § 63-1-150 and T.C.A. § 68-11-272 as contemplated in these statutes. In any event, TMF as a matter of policy does not release copies of any of its records (which are unavailable elsewhere) that are necessarily protected as privileged and confidential under Tennessee and other laws. The TMF will release certain types of information as part of the advocacy process for physician participants. The TMF release forms need to be completed prior to such release. As a general matter, the release of such information is contemplated as part of the advocacy/after care contracts that participants sign. As an additional protection against unauthorized releases (especially by third parties who receive such advocacy information), the PHP requires that the applicable consent and authorization form(s) be completed by each participant *prior to the requested communication or advocacy event.*

RELEASE FORM EXPLANATION: This form has an acknowledgement noting that you have received a copy of this privacy policy. The form authorizes other entities and individuals to release information about you **TO** the TMF-PHP. This is particularly helpful as the PHP follows you, for example, through the assessment and treatment processes. Without this form, the PHP likely will not be able to assist you or advocate for you.

This form also authorizes the TMF-PHP to release information **FROM** its participant file about you as part of the ongoing advocacy process to entities or individuals who need the information to determine whether, for example, your hospital privileges, HMA credentials, or medical license should be kept in place. All requests TMF receives for written information regarding your participation with the program must be submitted to our offices in writing. If you receive a written request for information, it is important that you send us a copy of the request and that the language in the release reflects the information sought. For example, some employers are satisfied with a simple verification that a physician is in the program whereas others require a more detailed account of the physician's participation. It is critical that we understand the extent of the inquiry so that we know what information to release.

We encourage you to rely upon your personal legal counsel in completing this form. Be sure to submit your request to us one month prior to any deadline and to let us know the deadline. Due to demands on our PHP staff, TMF-PHP policy states that request for advocacy letters or other documentation information will be fulfilled within 10 business days following the TMF-PHP's receipt of the written request including completion of the applicable consent and authorization form(s). For further information, please contact Jeanne Breard, TMF-PHP Clinical Coordinator, at (615) 467-6411.

PHYSICIAN'S HEALTH PROGRAM (PHP)
5141 Virginia Way, Suite 110
Brentwood, TN 37027
Tel. (615) 467-6411
Fax. (615) 467-6419

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION TO & FROM TMF-PHP

I, _____
(Please print Participants Name)

Home Address: _____
(Street, City, State, Zip)

Office Address: _____
(Street, City, State, Zip)

Home Phone: _____ Office Phone: _____

I ACKNOWLEDGE RECEIPT OF TMF'S PRIVACY POLICY AND HEREBY AUTHORIZE:

The **TENNESSEE MEDICAL FOUNDATION PHYSICIAN'S HEALTH PROGRAM'S STAFF**

and _____
(Please list name and contact information of the organization and/or person with whom we may correspond.)

Address: _____

Email Address and/or Fax No: _____

Phone Number: _____

TO DISCLOSE/RELEASE TO EACH OTHER:
(Please check all that are appropriate)

- ☐ Copy(ies) or summary(ies) of information pertinent to TMF-PHP participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations.
- ☐ To Re-Disclose _____
  (Note: Once re-disclosed, information may not be HIPAA protected.)
- ☐ Other _____

PURPOSE:

- ☐ To facilitate case management and advocacy efforts
- ☐ Other _____

Participant's Signature: _____

Date of Signature: _____

EXPIRATION: THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE TMF PHP WHICH IS TO MAKE THIS DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION/CONSENT. ONCE RE-DISCLOSED, THE INFORMATION RECIPIENT(S) POTENTIALLY MAY RE-DISCLOSE TO PERSONS/ENTITIES NOT SUBJECT TO HIPAA. THE TMF-PHP RESERVES THE RIGHT TO CHANGE ITS PRIVACY PRACTICE. THE PARTICIPANT MAY REQUEST A RESTRICTION OF THE USE OF COVERED INFORMATION, BUT, UNLESS IT AGREES, THE TMF-PHP IS NOT REQUIRED TO HONOR THAT REQUEST. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE THIRTY (30) DAYS AFTER SUCCESSFUL COMPLETION OF THE TMF-PHP PARTICIPATION OR AFTERCARE CONTRACT UNLESS ANOTHER DATE IS INDICATED: _____/_____/_____.

Physician's Health Program (PHP)
5141 Virginia Way, Ste. 110
Brentwood, Tennessee 37027
Telephone (615) 467-6411 Fax **(615) 467-6419**

AUTHORIZATION AND CONSENT FOR EXCHANGE OF INFORMATION BETWEEN TMF PHP AND WORK SITE MONITOR

I, _____
(Please print Participant Name legibly)

Primary Phone _____ Secondary Phone: _____

Home Address: _____
Street City State Zip

Office Address: _____
Street City State Zip

HEREBY AUTHORIZE:
The TENNESSEE MEDICAL FOUNDATION PHYSICIANS HEALTH PROGRAM'S STAFF

And _____
(Work Site Monitor) (Email Address) (Phone Number)

1. TO EXCHANGE INFORMATION

2. PURPOSE: To facilitate case management, advocacy efforts, and/or aftercare follow-up and to assess on-going progress

3. Participant's Signature: _____

4. Date of Signature _____/_____/_____

Expiration: THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION BY THE PARTICIPANT AT ANY TIME. I MAY CHANGE MY WORK SITE MONITOR AT ANY TIME. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE IN ONE YEAR FROM THE ABOVE DATE AND WILL REQUIRE ANNUAL RENEWAL.

Revised 8/2017

Verification of Work Site Monitor
Please print legibly

TMF Participant Name: _____

Work Site Monitor Contact information

(* indicates required)

*** Name:** _____

*** Work Phone:** _____

Or

*** Cell Phone:** _____

Pager: _____

*** Email address:** _____

*** Address:** _____

*** City:** _____

*** State:** _____ *** Zip code:** _____

Please return via fax to: 615-467-6419

Attention: Ms. Jeanne Breard **or** Mr. Mike Todd

or mail to:

Tennessee Medical Foundation
5141 Virginia Way, Ste. 110
Brentwood, Tennessee 37027

Do you employ, supervise, pay or have a business relationship with your Work Site Monitor?

Circle One: Yes No

TMF 12-Step
Attendance Sheet

Participants Name: _____

TMF Contract Date: _____

Meeting Verification:

	Date	Time	Group	Chairperson Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

Annals of Internal Medicine

POSITION PAPER

Physician Impairment and Rehabilitation: Reintegration Into Medical Practice While Ensuring Patient Safety: A Position Paper From the American College of Physicians

Philip J. Candilis, MD; Daniel T. Kim, MA, MPH; and Lois Snyder Sulmasy, JD; for the ACP Ethics, Professionalism and Human Rights Committee*

Physician impairment, the inability to carry out patient care responsibilities safely and effectively, is a problem of functioning. However, the presence or treatment of a potentially impairing illness or other condition does not necessarily imply impairment. This American College of Physicians position paper examines the professional duties and principles that should guide the response of colleagues and the profession to physician impairment. The physician should be rehabilitated and reintegrated into medical practice whenever possible without compromising patient safety. At the same time, physicians have a duty to seek help when they are unable to provide safe care. When identifying and assisting colleagues who might be impaired, physicians should act on collegial concern as well as ethical and legal guidelines that require reporting of behavior that puts patients at risk. Health care institutions and the profession should support practice environments in which patient safety is prioritized and physician wellness and well-being are addressed. Physician health programs should be committed to best practices that safeguard patient safety and the rights of physician-patients.

Ann Intern Med. doi:10.7326/M18-3605 **Annals.org**
For author affiliations, see end of text.
This article was published at Annals.org on 4 June 2019.

Physicians share a commitment to care for ill persons, including each other. When physicians become impaired and are unable to practice competently, they should seek medical help and assistance in caring for their patients. When they cannot or do not do so, the profession and individual physicians have a responsibility to safeguard the welfare of patients and assist colleagues in obtaining help.

The American College of Physicians (ACP) has long distinguished impairment from the underlying illness or condition (1). Impairment interferes with the ability of a physician to carry out patient care responsibilities safely and effectively. It can have many causes, including substance use disorders, mental illness, profound fatigue, or a decline in cognitive or motor skills due to age or disease (1, 2). Professional self-regulation, including state licensure practices, should focus on the functional impact of impairment. The presence or treatment of a disorder does not necessarily imply that the physician is impaired (1).

When identifying and assisting colleagues who might be impaired, physicians should act on collegial concern as well as ethical and legal guidelines that require reporting behavior that puts patients at risk (1, 3–5). A stepwise approach should be taken, starting with a sensitive but forthright discussion with the person if patient harm is unlikely and progressing to a report to licensing boards or clinical supervisors if patient harm is imminent or suspected. In uncertain cases, physicians should seek counsel from designated officials or supervisors (1).

Medical institutions should establish clear policies for handling and educating staff physicians and trainees on the referral, rehabilitation, and reintegration of impaired physicians, including respect for the confidentiality of those who report and are reported (6). Outreach, education, and collaborative leadership at every level of organized medicine, including physician health programs (PHPs), state medical boards, professional societies, and health care institutions, are needed to support physician wellness and well-being.

The goal for professionals, organizations, and communities should be to rehabilitate impaired physicians and facilitate reintegration into medical practice whenever possible. Rehabilitation should focus on treating the underlying illness or condition (7, 8), with different causes of impairment requiring different types of assessment and support. Clinical evaluation and treatment should be based on standards of care. A physician's readiness to reintegrate should be determined on a case-by-case basis (9), focusing on the functional impact of the impairment and recognizing that its ef-

See also:

Editorial comment

* This paper, written by Philip J. Candilis, MD; Daniel T. Kim, MA, MPH; and Lois Snyder Sulmasy, JD, was developed for the American College of Physicians Ethics, Professionalism and Human Rights Committee. Individuals who served on the 2018–2019 ACP Ethics, Professionalism and Human Rights Committee at the time the paper was approved by the committee and who contributed to the paper were Thomas A. Bledsoe, MD (*Chair*); Omar T. Atiq, MD (*Vice Chair*); John B. Bundrick, MD; Betty Chang, MDCM, PhD; Lydia S. Dugdale, MD; Andrew Dunn, MD, MPH; LT COL Joshua D. Hartzell, MD, USA; Thomas S. Huddle, MD, PhD; Janet A. Jokela, MD, MPH; Diana Jung; Mark A. Levine, MD; Ana María López, MD, MPH; Neena Mohan, MD; and Paul S. Mueller, MD, MPH. Approved by the ACP Board of Regents on 3 November 2018.

fects are role-specific and related to the physician's specialty and clinical responsibilities.

Most states have PHPs, many of which have demonstrated success in assisting impaired physicians and trainees, especially those with substance use disorders (10–16). However, PHPs vary in their approaches, and impairment may not be recognized or addressed by individual physicians or their colleagues. Also, some PHPs have been scrutinized for the adequacy of their protections of the rights and interests of physician participants (17).

This ACP position paper reaffirms the responsibility of physicians and the profession to protect patients while detailing the foundational principles and professional duties that should guide the response to physician impairment. This executive summary is a synopsis of ACP's positions; the rationale for each is presented in the Appendix.

METHODS

This position paper was developed on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews on PubMed and Google Scholar, the EPHRC evaluated and discussed several drafts of the paper, and the paper was reviewed by members of the ACP Board of Governors, Board of Regents, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts. The paper was revised on the basis of comments from these groups and individuals. The ACP Board of Regents reviewed and approved the paper on 3 November 2018.

POSITIONS

1. The professional duties of competence and self-regulation require physicians to recognize and address physician illness and impairment.

2. The distinction between functional impairment and potentially impairing illness should guide identification of and assistance for the impaired physician.

3. Best practices for PHPs should be developed systematically, informed by available evidence and further research.

4. PHPs should meet the goals of physician rehabilitation and reintegration in the context of established standards of ethics and with safeguards for both patient safety and physician rights.

5. Maintenance of physician wellness with the goal of well-being must be a professional priority of the health care community promoted among colleagues and learners.

CONCLUSION

Physician impairment is a problem of professional functioning that has implications for both patients and impaired physicians. Impaired physicians should seek treatment when they are unable to provide safe care. Colleagues should assist and refer those who are impaired and who need medical assistance, including help in caring for their patients.

The profession, health care institutions, and organizations should promote practice environments in which patient safety is prioritized and physician wellness and well-being are addressed. State PHPs should be committed to best practices that help ensure patient safety, protect the rights and interests of physicians, and advance excellence in the rehabilitation of physicians back into medical practice.

The privilege of medical practice is predicated on the physician's and the profession's commitment to providing safe, competent, and ethical patient care. Self-regulation is part of the definition of a profession: Members of the medical profession share in the responsibility to safeguard patients from harm. This is one of the ways in which physicians demonstrate the commitment to care for ill persons—including caring for one another.

APPENDIX: EXPANDED RATIONALE

Position 1

The professional duties of competence and self-regulation require physicians to recognize and address physician illness and impairment.

Self-regulation is part of the definition of a profession (1) and of the medical profession's social contract with society, a privilege that is predicated on the profession upholding standards of competence and conduct that ensure safe, ethical, and effective patient care (18, 19). Society grants professional prerogatives to physicians "with the expectation that physicians will use their position for the benefit of patients. In turn, physicians are responsible and accountable to society for their professional actions. Society grants physicians the rights, privileges, and duties pertinent to the patient–physician relationship and therefore has the right to require that physicians be competent, knowledgeable, and respectful of the patient as a person" (1). Physicians should strive to recognize when they are not able to provide appropriate care and seek treatment. Colleagues may need to assist—or, as appropriate, report—impaired physicians who require medical assistance and help in caring for their patients (1).

The ACP Ethics Manual has long urged a focus on the importance of an impairment's functional impact—that is, the inability to carry out patient responsibilities safely and effectively. Physician impairment may have various causes, including substance use disorders, mental illness, profound fatigue, or a decline in cognitive or motor skills due to age or disease. Physical lim-

itations resulting from a disability, such as a hearing impairment, or a medical event, such as a stroke, may also impede a physician's ability to fulfill patient care responsibilities. However, the presence of a disorder or treatment for it does not necessarily imply impairment (discussed further in position 2) (1). The exact prevalence of physician impairment is unknown, but several important causes are common and require different types of assessment and support.

Although impairment has many potential causes, the most commonly studied is substance use disorders. Rates of alcohol use disorders among physicians, especially women, are equal to or greater than that of the general population—as high as 21.4% and 25.6% among female physicians and surgeons, respectively, versus 12.9% and 13.9% among their male counterparts (20, 21). In contrast, men are twice as likely as women to meet the criteria for alcohol abuse or dependence in the general population (21). The gender difference among physicians has not been fully explained but may be due to more conflicts between work and home for female physicians (20). Other contemporary issues, such as the implications of use of legal cannabis or medication-assisted treatment (for example, buprenorphine or other partial opioid agonists), also require further study and guidance (22).

Substance use disorders are also strongly associated with common mental health conditions (23–25), which can also lead to impairment. In a large 2014 survey, 40% of early-career physicians and 50.8% of residents screened positive for depression, and 6.3% and 8.1%, respectively, screened positive for suicidal ideation (24). Cognitive decline has also received more attention recently as a potential cause of impairment, especially as the number of practicing physicians aged 65 years or older grows rapidly (26–28). This will require a renewed focus on cognitive signs that signal risk to patients.

Physician impairment is too often unrecognized or untreated. Studies suggest that physicians are less likely than members of the general population to obtain needed care and are more likely to self-diagnose and self-treat (29–31). For example, in a study of physicians being monitored for misuse of prescription drugs, "self-medication" was a leading reason for misuse (32). Physicians may avoid seeking medical help because they fear loss of confidentiality and privacy, loss of livelihood, or the appearance of vulnerability or because they deny or subordinate their personal needs to practice demands and therefore do not recognize the impairment (33). The stigma of addiction and mental illness added to the concern that diagnosis may lead to professional liability or loss of licensure can compel physicians to suffer in silence and delay seeking help (34–36).

Physicians also do not always refer impaired colleagues. In a 2010 survey of 2938 physicians, almost a third with knowledge of an impaired or incompetent colleague did not report this to a relevant authority, and more than a third did not agree that physicians should report colleagues at all. The most common reasons for not reporting were the expectation that someone else would do so or that no action would result. Other reasons included fear of retribution, belief that it was not their responsibility, and worries about excessive punishment (37). In addition, colleagues may harbor concerns about misjudging someone as impaired. More data about current practices and behaviors would be helpful, and ACP encourages further study in this area.

None of these concerns diminish physicians' shared responsibility to protect patients and assist impaired colleagues. In uncertain cases, concerned colleagues should "seek counsel from a designated institutional or practice official, the departmental chair, or a senior member of the staff or the community" (1). Physicians must be careful in identifying someone as impaired, remembering that without a good-faith concern about a colleague's impairment or competence, it is unethical "to use the peer-review process to exclude another physician from practice, to restrict clinical privileges, or to otherwise harm the physician's practice" (1). Peer review is a vital element of the profession's duty of self-regulation and must not be misused. Physicians should be aware that oversight bodies reserve the right to make the ultimate judgment about patient harm or imminent risk, including whether and how to act on a report.

Physicians should take a collegial approach to helping one another, acting in a stepwise manner to assist a colleague who might be in need. When there is no likelihood of patient harm, a sensitive but direct discussion with the physician can raise relevant issues. By acting on collegial concern, as well as on ethical and state guidelines that require reporting of behavior that puts patients at risk (1, 3–5), physicians can urge an impaired colleague to explore voluntary options for evaluation and assistance. Reports to licensing boards or clinical supervisors are urgently needed when patient harm is imminent or suspected. Although reporting standards may vary by locality, the privacy of physicians and their patients is an important guiding principle. At each step, the confidentiality of those who report and those who are reported should be respected (6), with confidential follow-up provided to those who report if any recommendations result (37).

Position 2

The distinction between functional impairment and potentially impairing illness should guide identification of and assistance for the impaired physician.

The Federation of State Physician Health Programs (FSPHP) and the Federation of State Medical Boards (FSMB) maintain an important distinction in their policies governing functional impairment and potentially impairing illness (7, 35, 38). Impairment is a functional classification concerning the physician's inability to carry out patient care responsibilities safely and effectively. Illness does not necessarily signify impairment. This distinction has been central to the section on impaired physicians in many editions of the ACP Ethics Manual; the seventh edition states, "Impairment may result from use of psychoactive agents (alcohol or other substances, including prescription medications) or illness. Impairment may also be caused by a medical or mental health condition, the aging process, or profound fatigue that affects the cognitive or motor skills necessary to provide adequate care. The presence of these disorders or the fact that a physician is being treated for them does not necessarily imply impairment" (1).

Some licensure questions may be a barrier to recognition, referral, and treatment of impaired physicians (35, 39, 40). A resolution recently adopted by ACP advocates for "modernization of state licensure practices that focuses more on the functional impact of mental health diagnoses in physicians and limits additional administrative requirements so that it does not isolate prior or current mental health considerations from other medical considerations in the reporting process" (41). The American Medical Association (AMA) Council on Medical Education has also recommended that

> AMA urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept 'safe haven' non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety (42).

In keeping with the focus on functional impact, ACP recommends that licensure questions address current status rather than past history, not distinguish between mental and physical health, and elicit objective information about functional status. A model question proposed by the FSMB, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?" (35), contains helpful elements that focus on current status and make no distinction between physical and mental health. Although these are important steps forward, such licensure questions should also elicit objective information about functional status; otherwise, physicians who are in denial about their condition or for whom appropriate treatment is not restorative could just answer "no." Applying validated screening questions for use in individual self-assessment could also meaningfully improve the process.

Assistance for impaired physicians should focus on the underlying illness or condition (8, 38). Contemporary efforts to help impaired physicians have focused on treatment and rehabilitation and can be traced to a landmark report published in 1973 by the AMA Council on Mental Health (2, 43, 44). The impetus for that report was physician impairment due to "psychiatric disorders, including alcoholism and drug dependence." The report recognized the significant scope of problems affecting physicians, the failure of physicians to seek help, and the "conspiracy of silence" surrounding the issue. It helped reorient physician impairment from a disciplinary issue to an illness requiring rehabilitation. This continues to inform the work of PHPs today (8, 43).

Different causes of impairment require different types of assessment and support. Potential causes are not limited to addiction and psychiatric disorders; they can include many treatable and resistant conditions. For example, ACP and FSMB note that disruptive behavior (3) and cognitive decline (4) can cause impairment. Although they may be manifestations of underlying personality, psychiatric, or substance use disorders, disruptive behavior and cognitive decline are not illnesses per se. The former may be due to personality or character traits, interpersonal conflicts exacerbated by gender and cultural factors, or other external stressors (45, 46), and the latter may be caused by health problems associated with aging (4, 26). In all cases, different stages of progression or severity may warrant different forms of intervention.

The nature and severity of the impairing condition and the degree of risk posed to patients and others should inform best practices for assisting an impaired physician. Rehabilitation should be sought whenever possible so that the physician might safely return to practice. Evaluation and treatment should be clinically based according to standards of care. A physician's voluntary decision to seek or accept treatment should not "in [and] of itself, be used against the physician in disciplinary matters before the board" (38).

A physician's readiness to reintegrate into medical practice should be evaluated on a case-by-case basis (9). The determination should focus on the functional impact of the impairment, with the recognition that this is role-specific and that reintegration will therefore depend on the physician's specialty and clinical responsibilities. In all cases, continuing care and monitoring

should not compromise patient safety (8). Reasonable accommodations should be made to ensure that recovering physicians have the support they need to provide competent care. This may include time during the day for medical and therapy appointments, support group meetings, or urine screens and medical tests. More flexible shifts or gradual returns to work can be important corollaries to work schedule adjustments. When treatment or management of an impairing condition that is relevant to practice is not possible, the physician should discontinue practice. Retraining; mentoring; group support; or moving to related work, such as medical writing, may then be possible.

Position 3

Best practices for PHPs should be developed systematically, informed by available evidence and further research.

The profession assists impaired physicians primarily through state PHPs with varied organizational and operational structures. Physician health programs may be authorized or managed by the state medical board or medical society; almost all are nonprofit (47). Forty-six states and the District of Columbia have PHPs with the requisite staff and recognition of organized medicine in their state to be members of the FSPHP (48). However, financial support varies, leading the FSPHP to call for programs to be adequately funded by their sponsors so they can offer an appropriate range of services.

The FSPHP issues consensus policy statements and guidelines for its member PHPs (8), and the FSMB issues its own policy for state medical boards that support or establish PHPs (38). Most PHPs do not report monitored physicians to state licensure boards in cases of voluntary referral unless the physician is noncompliant or relapses. Referrals that are mandated by the state medical board have tighter reporting requirements, although PHPs maintain barriers between therapy and monitoring so that treatment can remain confidential (38). Physician health programs monitor and oversee treatment but do not treat physicians directly; most refer them to community consultants specializing in physician health for evaluation or diagnosis. Physician health programs also work with and advise third-party evaluation and treatment services, contract with the physician on treatment and monitoring plans, and serve as a repository for compliance records (38, 47).

Studies have shown some PHPs to be highly effective in monitoring addiction. In a 2008 retrospective cohort study involving 16 PHPs, 78.7% of physicians (n = 904) were still licensed and working at the 5-year follow-up, compared with relapse rates of 40% to 60% in standard nonphysician programs (10). Follow-up studies on the same data set indicated similar rates across specialties (11–15), and older studies show that success rates have held across time and states (49, 50). The effectiveness of PHPs for physicians with mental and behavioral health problems is less well established. A 2007 study of the Massachusetts PHP found similar rates of success between mental and behavioral health problems (n = 63) and substance use disorders (n = 132): 74% and 75% of participants, respectively, completed their monitoring contracts (16). Another study showed that completion of monitoring contracts in the Colorado PHP (n = 818) was associated with lower malpractice risk compared with a matched cohort (51).

More studies of state PHPs with different organizational and operational structures are needed to identify which PHPs are successful and the factors associated with success. Current studies rely on data from PHPs that may not be representative of other programs. For example, many recent studies on addiction-related illnesses used data from the 16 PHPs studied in 2008, which were selected for their ability to provide analyzable records and information on participants' personal characteristics, participation in treatment, and outcomes. The study notes that the 16 PHPs were likely the best-funded or best-led programs at the time (10).

Future studies should also explore gender differences in rates of PHP enrollment and treatment success. As noted in position 1, rates of alcohol dependence seem to be higher among female physicians than male physicians nationally. However, the 2007 Massachusetts PHP study found that 82% of enrollees were male and 18% were female, even though an estimated 26% of physicians in Massachusetts are female (16). The study also found a statistically significant difference in time to relapse after mental health and substance use treatments, with women relapsing sooner than men in each. The disparity may be due to differences in "disease severity at baseline or inadequate treatment and support services for women during the monitoring period" (16). The generalizability of the data should be explored.

National efforts by the FSPHP are under way to help ensure the quality, accountability, and consistency of PHP operations by developing performance and independent review procedures; these efforts should be encouraged (52, 53). Physician health programs should be committed to providing effective data collection as well as services. Consensus definitions of recovery and completion can enable better interpretation of information across PHPs. Evaluation of PHP cases and finances is currently done by independent boards of directors and community advisory boards and can include review of data that indicate professional quality.

The FSMB Policy on Physician Impairment, which was adopted in 2011, "provides guidance to state medical and osteopathic boards for including PHPs in their efforts to protect the public" (38). It defines terms, describes types of impairment, lists elements of an effec-

tive PHP, defines the value of PHPs, and identifies regulatory issues. Such policy statements are important in defining first principles and should evolve to address contemporary challenges, such as the opioid crisis, which may affect physicians as both clinicians and patients. Collaborative policies informed by physician organizations can provide standards that emphasize early detection and confidentiality and articulate common criteria for patient referral, evaluation and assessment, treatment, continuing care, relapse management, and monitoring. As the FSMB policy notes, PHP services should be insulated as much as possible from "changing political pressures" (38), as when medical board membership changes or legislative agendas shift.

Position 4

PHPs should meet the goals of physician rehabilitation and reintegration in the context of established standards of ethics and with safeguards for both patient safety and physician rights.

Practicing medicine is a privilege. States issue medical licenses under specific conditions of competent practice, and physicians demonstrate competence to earn licensure and accept oversight conditions each time they renew. Because PHPs divert physicians from board discipline, they offer an alternative to professional sanctions. Although the choice to participate in a PHP is restricted given state-specific obligations to report under certain conditions, the restriction is based on legitimate ethical and social claims (19). Patients and the states representing them have a strong interest in how the privilege of a professional license is exercised, especially among safety-sensitive professions.

While protecting patient safety, PHPs must also ensure procedural fairness for physicians. This is an essential element of monitoring that requires administrative and legal oversight ranging from internal mechanisms and community oversight to administrative law and civil procedure. For example, when physicians challenge case management, initial appeals can be made directly to the PHP director. Some PHPs convene all staff to review complaints or appeals. Clinical advisory committees, clinical experts from the community, and boards of directors are other available review mechanisms. For example, after a state audit (17), the North Carolina PHP added a case review committee to the compliance committee overseeing individual cases and reviewing cases anonymously with the licensing board. Physicians considering participation in a PHP should be informed before intake that they can access such review committees if there are disagreements. These are among the approaches that can serve professional standards of objectivity and community oversight.

Important ethical practices underlying such standards include being attentive to and having processes in place to manage competing and conflicting interests. Physician health programs should seek funding from diverse sources so that competing interests do not interfere with physician monitoring. Various constituencies, such as hospitals, insurers, boards, and medical societies, can support PHPs but should not influence day-to-day operations and case management. Physician health programs should also exercise due diligence to avoid competing interests created by any relationship with referral treatment programs or monitoring laboratories. The ACP has long held that "it is . . . unethical to participate in any arrangement that links income generation explicitly or implicitly to equipment or facility usage . . ." (54).

Physician health programs should ensure that all operations and services are adequately funded. Such funding often varies greatly. A national survey of PHPs in 2009 found that annual operating budgets ranged from $21 250 to $1.5 million (median, $270 000) (47). Physician health programs must decide at what level their resources allow adequate assessment, support, monitoring, and advocacy and must prioritize their services when staffing and funding are limited. Although this may depend on legislative and regulatory mandates as well as funding streams, prioritizing services is an established practice among PHPs: All currently serve participants with addictions, most address mental health conditions and psychiatric illness, and a smaller number address disruptive behavior and cognitive and physical illness (55). A few offer coaching for less distressed participants.

Financial considerations can be challenging for participants as well. Assessment and treatment for participation in PHPs may not be covered by insurance. Treatment referral centers, which are often required for the more intense work of recovery among physician-patients, are expensive. To address these concerns, PHPs may ask local experts to adjust their fees for independent assessments and advocate for scholarship programs or other financial assistance at treatment centers. Seeking treatment locally may be preferable and less expensive for some participants, whereas others may prefer to be treated at a geographic distance from their communities. Out-of-state treatment centers may have the specific expertise needed for a particular condition. Choice and expertise should be fundamental elements of any community's commitment to rehabilitation and reintegration.

Informed consent standards, an element of ethical practice in physician health, should underscore openness and transparency and require confidentiality warnings beyond those used in general medical practice. Because information disclosure may result in reports to licensing boards, PHPs should inform participants of the limits of confidentiality and the consequences of self-reports. Participants should be familiar with the contents of their agreements, testing schedules, and

the consequences of nonadherence. For example, they should be informed that a positive result on a toxicology test may result in immediate board reports in some jurisdictions, and PHPs should seek to determine whether the full clinical picture—especially among voluntary participants—truly signals relapse. Contacting work monitors or other collateral information sources is an appropriate mechanism for this exploration. The decision to report to a licensing board is a crucial element of PHP practice, and the ethics of this decision merit close attention in discussions between PHPs and boards and between PHPs and their participants.

Such safeguards as appeals mechanisms, independent oversight, and robust informed consent can be undermined by poor communication among PHPs, workplace monitors, and treating clinicians. Case managers at PHPs rely on workplace monitors (colleagues who observe and support participating physicians) to be the eyes and ears of clinicians and PHPs. Their communication is the sine qua non of monitoring and reintegration. Case managers and workplace monitors who do not appreciate the confidentiality protections of treatment and treating clinicians who do not adhere to monitoring requirements can undermine the collaboration required for rehabilitation and reintegration of physicians into practice. Treating clinicians and workplace monitors who report basic information to monitoring programs, such as attendance, sobriety, and behavioral stability, should meet professional standards and ensure that treatment remains confidential. Education and vetting knowledgeable community partners are therefore critical to successful reintegration.

Position 5

Maintenance of physician wellness with the goal of well-being must be a professional priority of the health care community promoted among colleagues and learners.

Clinician wellness and well-being need to be addressed in multiple ways, including at the organizational level. Special attention should be paid to preventive and holistic approaches. The profession and health care institutions should foster an appropriate environment and culture for promoting wellness and well-being, including helping an impaired or distressed colleague. The term "burnout" seems inadequate because it is often taken to imply that physicians should simply be more resilient. Optimizing clinician well-being requires attention to the deprofessionalization and structural problems in the current practice environment that can lead to demoralization. Emotional exhaustion, cynicism, and detachment directly affect patient care and place patient safety at risk (24, 35) and should be a focus of training and monitoring similar to the Accreditation Council for Graduate Medical Education program requirements for fatigue mitigation among attending physicians and trainees (56). Support for physician well-being requires outreach, education, and collaborative leadership at every level of organized medicine, including PHPs, state medical boards, professional societies, and health care institutions.

Support for physician wellness and well-being may help reduce incidence of impairment (22). Institutions should also establish policies for handling and educating staff physicians and trainees on referral, rehabilitation, and reintegration of impaired physicians. Some have called on institutions to act more directly to identify impaired physicians, advocating for "a routine, formal, proactive system of monitoring that uses validated measures to focus strictly on clinical and behavioral performance" (57, 58), but some proposals, such as mandatory drug testing and age-based cognitive screening, have been controversial. Although blanket screening diminishes the flexibility of individualized case and risk assessment, it may be a strategy for overcoming the hesitation to report one's own health difficulties.

As part of the medical profession's social contract, physician well-being should be identified as a quality marker for healthy organizations and physician communities (59). The greater the emphasis on well-being, the greater the effect on physician recruitment and retention (60). Individuals, families, and society commit considerable resources to the development of medical careers. A focus on physician health can save lives, relationships, and membership in the profession—a profession that requires substantial emotional, financial, and time investment. Peer support in particular is a common-sense and evidence-based approach that can promote physician well-being (61, 62). The ACP offers resources for physician well-being and professional satisfaction (www.acponline.org/practice-resources/physician-well-being-and-professional-satisfaction). Patients may also support expanded systemic and professional initiatives that attend to the well-being and wellness of their clinicians (63).

From Saint Elizabeths Hospital and George Washington University School of Medicine, Washington, DC (P.J.C.); and American College of Physicians, Philadelphia, Pennsylvania (D.T.K., L.S.S.).

Acknowledgment: Philip J. Candilis, MD, received compensation from ACP for consulting on and coauthoring the manuscript. The authors and the ACP Ethics, Professionalism and Human Rights Committee thank peer reviewers Chris Bundy, MD; Humayun J. Chaudhry, DO; Paul H. Earley, MD; John A. Fromson, MD; and P. Bradley Hall, MD, and the many ACP leadership and journal reviewers of the paper for helpful comments on drafts, as well as Kathy Wynkoop of the ACP Center for Ethics and Professionalism.

Financial Support: Financial support for the development of this paper comes exclusively from the ACP operating budget.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M18-3605.

Corresponding Author: Lois Snyder Sulmasy, JD, Director, ACP Center for Ethics and Professionalism, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106; e-mail, lsnyder@acponline.org.

Current author addresses and author contributions are available at Annals.org.

References

1. **Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee.** American College of Physicians ethics manual: seventh edition. Ann Intern Med. 2019;170:S1-S32. [PMID: 30641552] doi:10.7326/M18-2160
2. The sick physician. Impairment by psychiatric disorders, including alcoholism and drug dependence. JAMA. 1973;223:684-7. [PMID: 4739202]
3. **Mueller P, Snyder L.** Dealing with the "Disruptive" Physician Colleague. American College of Physicians Ethics Case Studies. Accessed at www.medscape.org/viewarticle/590319 on 15 May 2018.
4. **Mathes M, Sulmasy LS.** When an Aging Colleague Seems Impaired. American College of Physicians Ethics Case Studies. Accessed at www.medscape.org/viewarticle/813533 on 15 May 2018.
5. **American Medical Association.** Opinion 9.4.2: Reporting Incompetent or Unethical Behaviors by Colleagues. In: AMA Code of Medical Ethics. Chicago: American Med Assoc; 2016. Accessed at www.ama-assn.org/delivering-care/reporting-incompetent-or-unethical-behaviors-colleagues on 18 June 2018.
6. **American Medical Association.** Physician Health Programs Act. 2016. Accessed at www.fsphp.org/ama-physician-health-programs-act-model-bill on 8 October 2018.
7. **Federation of State Physician Health Programs.** Public Policy Statement: Physician Illness vs. Impairment. 30 July 2008. Accessed at www.fsphp.org/public-policy-statement-physician-illness-vs-impairment on 23 April 2019.
8. **Federation of State Physician Health Programs.** Physician Health Program Guidelines. December 2005. Accessed at www.fsphp.org/2005-fsphp-physician-health-program-guidelines on 23 April 2019.
9. **Federation of State Medical Boards.** Report of the Special Committee on Reentry for the Ill Physician. April 2013. Accessed at www.fsmb.org/globalassets/advocacy/policies/reentry-for-the-Ill-physician.pdf on 9 July 2018.
10. **McLellan AT, Skipper GS, Campbell M, DuPont RL.** Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ. 2008;337:a2038. [PMID: 18984632] doi:10.1136/bmj.a2038
11. **Buhl A, Oreskovich MR, Meredith CW, Campbell MD, Dupont RL.** Prognosis for the recovery of surgeons from chemical dependency: a 5-year outcome study. Arch Surg. 2011;146:1286-91. [PMID: 22106321] doi:10.1001/archsurg.2011.271
12. **Skipper GE, Campbell MD, Dupont RL.** Anesthesiologists with substance use disorders: a 5-year outcome study from 16 state physician health programs. Anesth Analg. 2009;109:891-6. [PMID: 19690263] doi:10.1213/ane.0b013e3181adc39d
13. **Rose JS, Campbell M, Skipper G.** Prognosis for emergency physician with substance abuse recovery: 5-year outcome study. West J Emerg Med. 2014;15:20-5. [PMID: 24696748] doi:10.5811/westjem.2013.7.17871
14. **Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL.** Family medicine physicians with substance use disorder: a 5-year outcome study. J Addict Med. 2017;11:93-7. [PMID: 28067757] doi:10.1097/ADM.0000000000000278
15. **Yellowlees PM, Campbell MD, Rose JS, Burke Parish M, Ferrer D, Scher LM, et al.** Psychiatrists with substance use disorders: positive treatment outcomes from physician health programs. Psychiatr Serv. 2014;65:1492-5. [PMID: 25270988] doi:10.1176/appi.ps.201300472
16. **Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Fromson JA.** Outcomes of a monitoring program for physicians with mental and behavioral health problems. J Psychiatr Pract. 2007;13:25-32. [PMID: 17242589]
17. **Wood BA; North Carolina Office of the State Auditor.** Performance Audit: North Carolina Physicians Health Program. April 2014. Accessed at www.ncauditor.net/EPSWeb/Reports/performance/per-2013-8141.pdf on 15 January 2018.
18. **Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL.** Medical professionalism in society. N Engl J Med. 1999;341:1612-6. [PMID: 10577119]
19. **Bonnie RJ, Monahan J.** License as leverage: mandating treatment for professionals. Int J Forensic Ment Health. 2004;3:131-8. doi:10.2139/ssrn.1758874
20. **Oreskovich MR, Shanafelt T, Dyrbye LN, Tan L, Sotile W, Satele D, et al.** The prevalence of substance use disorders in American physicians. Am J Addict. 2015;24:30-8. [PMID: 25823633] doi:10.1111/ajad.12173
21. **Oreskovich MR, Kaups KL, Balch CM, Hanks JB, Satele D, Sloan J, et al.** Prevalence of alcohol use disorders among American surgeons. Arch Surg. 2012;147:168-74. [PMID: 22351913] doi:10.1001/archsurg.2011.1481
22. **Earley PH.** Physicians health programs and addiction among physicians. In: Miller SC, Fiellin DA, Rosenthal RN, Saitz R, eds. The ASAM Principles of Addiction Medicine, Sixth Edition. Philadelphia: Wolters Kluwer; 2018.
23. **Mata DA, Ramos MA, Bansal N, Khan R, Guille C, Di Angelantonio E, et al.** Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. JAMA. 2015;314:2373-83. [PMID: 26647259] doi:10.1001/jama.2015.15845
24. **Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, et al.** Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89:443-51. [PMID: 24448053] doi:10.1097/ACM.0000000000000134
25. **Ruitenburg MM, Frings-Dresen MH, Sluiter JK.** The prevalence of common mental disorders among hospital physicians and their association with self-reported work ability: a cross-sectional study. BMC Health Serv Res. 2012;12:292-8. [PMID: 22938170]
26. **Dellinger EP, Pellegrini CA, Gallagher TH.** The aging physician and the medical profession: a review. JAMA Surg. 2017;152:967-71. [PMID: 28724142] doi:10.1001/jamasurg.2017.2342
27. **American College of Surgeons Board of Governors Physician Competency and Health Workgroup.** Statement on the aging surgeon. Bull Am Coll Surg. 2016;101:42-3. [PMID: 26891501]
28. **American Medical Association.** Competency and the Aging Physician. Report 5 of the Council on Medical Education (A-15). Chicago: American Med Assoc; 2015. Accessed at www.cppph.org/wp-content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf on 15 May 2018.
29. **Steffen MW, Hagen PT, Benkhadra K, Molella RG, Newcomb RD, Murad MH.** A survey of physicians' perceptions of their health care needs. Occup Med (Lond). 2015;65:49-53. [PMID: 25336036] doi:10.1093/occmed/kqu145
30. **Chiu YL, Kao S, Lin HC, Tsai MC, Lee CZ.** Healthcare service utilization for practicing physicians: a population-based study. PLoS One.2016;11:e0130690.[PMID:26752592]doi:10.1371/journal.pone.0130690
31. **Benkhadra K, Adusumalli J, Rajjo T, Hagen PT, Wang Z, Murad MH.** A survey of health care needs of physicians. BMC Health Serv Res. 2016;16:472. [PMID: 27600560] doi:10.1186/s12913-016-1728-4
32. **Merlo LJ, Singhakant S, Cummings SM, Cottler LB.** Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. J Addict Med. 2013;7:349-53. [PMID: 24089039] doi:10.1097/ADM.0b013e31829da074
33. **Schneck SA.** "Doctoring" doctors and their families. JAMA. 1998;280:2039-42. [PMID: 9863860]

34. **Merlo LJ.** A piece of my mind: healing physicians. JAMA. 2016; 316:2489-90. [PMID: 27997657] doi:10.1001/jama.2016.10339
35. **Federation of State Medical Boards.** Physician Wellness and Burnout. April 2018. Accessed at www.fsmb.org/globalassets /advocacy/policies/policy-on-wellness-and-burnout.pdf on 2 August 2018.
36. **American Society of Addiction Medicine.** Public Policy on Discrimination and the Addicted Professional. Rockville, MD: American Society of Addiction Medicine; 2011. Accessed at www.asam.org /advocacy/find-a-policy-statement/view-statement/public-policy -statements/2011/12/16/discrimination-and-the-addicted-professional on 8 October 2018.
37. **DesRoches CM, Rao SR, Fromson JA, Birnbaum RJ, Iezzoni L, Vogeli C, et al.** Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. JAMA. 2010;304:187-93. [PMID: 20628132] doi:10.1001/jama.2010 .921
38. **Federation of State Medical Boards.** Policy on Physician Impairment. April 2011. Accessed at www.fsmb.org/Media/Default/PDF /FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf on 12 January 2018.
39. **Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD.** Medical licensure questions and physician reluctance to seek care for mental health conditions. Mayo Clin Proc. 2017;92: 1486-93. [PMID: 28982484] doi:10.1016/j.mayocp.2017.06.020
40. **Worley LL.** Our fallen peers: a mandate for change. Acad Psychiatry. 2008;32:8-12. [PMID: 18270275] doi:10.1176/appi.ap.32.1.8
41. **American College of Physicians.** Resolution 10-F17: Developing ACP Policy on Physician Impairment and Rehabilitation Towards Reintegration. 2017. Accessed at www.acponline.org/system/files /documents/about_acp/chapters/wi/f17_mtg_resolutions.pdf on 8 October 2018.
42. **American Medical Association.** Access to Confidential Health Services for Medical Students and Physicians. 2016. Accessed at www.ama-assn.org/sites/default/files/media-browser/i16-cme -reports.pdf on 8 October 2018.
43. **Federation of State Physician Health Programs.** About FSPHP. Accessed at www.fsphp.org/about on 10 February 2018.
44. **American Medical Association.** Report 2 of the Council on Science and Public Health (A-11). Physician Health Programs. Accessed at www.ama-assn.org/councils/council-science-public-health/physician -safety-csaph-council-reports on 30 April 2019.
45. **Reynolds NT.** Disruptive physician behavior: use and misuse of the label. J Med Regul. 2012;98:8-19.
46. **John PR, Heitt MC.** Disruptive physician behavior: the importance of recognition and intervention and its impact on patient safety. J Hosp Med. 2018;13:210-2. [PMID: 29505621] doi:10 .12788/jhm.2945
47. **DuPont RL, McLellan AT, Carr G, Gendel M, Skipper GE.** How are addicted physicians treated? A national survey of physician health programs. J Subst Abuse Treat. 2009;37:1-7. [PMID: 19482236] doi: 10.1016/j.jsat.2009.03.010
48. **Federation of State Physician Health Programs.** State Programs. Accessed at www.fsphp.org/state-programs on 16 May 2018.
49. **Shore JH.** The Oregon experience with impaired physicians on probation. An eight-year follow-up. JAMA. 1987;257:2931-4. [PMID: 3573292]
50. **Morse RM, Martin MA, Swenson WM, Niven RG.** Prognosis of physicians treated for alcoholism and drug dependence. JAMA. 1984;251:743-6. [PMID: 6694277]
51. **Brooks E, Gendel MH, Gundersen DC, Early SR, Schirrmacher R, Lembitz A, et al.** Physician health programmes and malpractice claims: reducing risk through monitoring. Occup Med (Lond). 2013; 63:274-80. [PMID: 23606266] doi:10.1093/occmed/kqt036
52. **Federation of State Physician Health Programs.** Performance Enhancement Review (PER) Guidelines. 2016. Accessed at www.fsphp.org /resource/physician-health-program-guidelines on 2 August 2018.
53. **Federation of State Physician Health Programs.** Membership update performance enhancement and effectiveness reviews (PEERs) of PHPs and provider accreditation [memorandum to FSPHP members]. 19 July 2018.
54. **Coyle SL; Ethics and Human Rights Committee, American College of Physicians-American Society of Internal Medicine.** Physician-industry relations. Part 1: individual physicians. Ann Intern Med. 2002;136:396-402. [PMID: 11874314]
55. **Carr GD, Hall PB, Finlayson R, DuPont RL.** Physician health programs: the US model. In: Brower KJ, Riba MB, eds. Physician Mental Health and Well-Being: Research and Practice. Dordrecht, the Netherlands: Springer; 2017:265-94.
56. **Accreditation Council for Graduate Medical Education.** ACGME Program Requirements for Graduate Medical Education in Internal Medicine. 2017. Accessed at www.acgme.org/Portals/0/PFAssets /ProgramRequirements/140_internal_medicine_2017-07-01.pdf on 18 June 2018.
57. **Leape LL, Fromson JA.** Problem doctors: is there a system-level solution? Ann Intern Med. 2006;144:107-15. [PMID: 16418410]
58. **Shojania KG, Dixon-Woods M.** 'Bad apples': time to redefine as a type of systems problem? [Editorial]. BMJ Qual Saf. 2013;22:528-31. [PMID: 23744535] doi:10.1136/bmjqs-2013-002138
59. **Thomas LR, Ripp JA, West CP.** Charter on physician well-being. JAMA. 2018;319:1541-2. [PMID: 29596592] doi:10.1001/jama.2018 .1331
60. **Shanafelt T, Goh J, Sinsky C.** The business case for investing in physician well-being. JAMA Intern Med. 2017;177:1826-32. [PMID: 28973070] doi:10.1001/jamainternmed.2017.4340
61. **Zwack J, Schweitzer J.** If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. Acad Med. 2013;88:382-9. [PMID: 23348093] doi:10 .1097/ACM.0b013e318281696b
62. **Sanchez LT, Candilis PJ, Arnstein F, Eaton J, Barnes Blood D, Chinman GA, et al.** Effectiveness of a unique support group for physicians in a physician health program. J Psychiatr Pract. 2016;22:56-63. [PMID: 26813489] doi:10.1097/PRA.0000000000000121
63. **Lemaire JB, Ewashina D, Polachek AJ, Dixit J, Yiu V.** Understanding how patients perceive physician wellness and its links to patient care: a qualitative study. PLoS One. 2018;13:e0196888. [PMID: 29763443] doi:10.1371/journal.pone.0196888

Current Author Addresses: Dr. Candilis: Interim Director of Medical Affairs, Saint Elizabeths Hospital, 1100 Alabama Avenue SE, Washington, DC 20032.
Mr. Kim: Senior Associate, ACP Center for Ethics and Professionalism, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.
Ms. Snyder Sulmasy: Director, ACP Center for Ethics and Professionalism, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.

Author Contributions: Conception and design: D.T. Kim, L. Snyder Sulmasy.
Analysis and interpretation of the data: P.J. Candilis, D.T. Kim, L. Snyder Sulmasy.
Drafting of the article: P.J. Candilis, D.T. Kim, L. Snyder Sulmasy.
Critical revision of the article for important intellectual content: P.J. Candilis, D.T. Kim, L. Snyder Sulmasy.
Final approval of the article: P.J. Candilis, D.T. Kim, L. Snyder Sulmasy.
Provision of study materials or patients: P.J. Candilis.
Administrative, technical, or logistic support: D.T. Kim, L. Snyder Sulmasy.
Collection and assembly of data: P.J. Candilis, D.T. Kim.

Handling Distressed Physician Behavior

Medical staff leaders increasingly are calling upon the Tennessee Medical Foundation Physician's Health Program (TMF PHP) to assist them with colleagues who have behavioral problems. These "distressed physicians" can present quite a challenge to all parties who must interact with them in the workplace.

Therefore, the TMF PHP has drafted this document to provide information on how best to identify and deal with physicians who are behaviorally distressed. The TMF designed this document to be used by hospital chiefs of staff, administrators, and medical staff service coordinators. It also may be adapted for use in a medical group setting as well as for other settings.

Who or what is a distressed physician?

Since the decision of Darling v. Charleston Memorial Hospital, where the court decided that hospitals and their governing bodies were more than realtors in providing space for independent contractors (physicians) to practice their art and were responsible to patients for the competence and continued supervision of physicians granted medical staff privileges (corporate liability), hospitals have effectively devised bylaws, policies and procedures to address physicians impaired by reason of physical or mental illness, including drug and alcohol abuse.

In recent years, there has been a marked increase in the rather amorphous category of "distressed" or "behaviorally handicapped" physician. Some possible causes for this increase have been theorized:

- The empowerment of groups that previously suffered this behavior in silence, certain that any complaint would be ignored or result in retribution. Many companies now, at the insistence of their insurance carriers, require "sensitivity training" that describes unacceptable behavior and instructs employees on the channels available to voice their grievances.
- Physicians who perceived themselves as independent entrepreneurs now find themselves subject to scrutiny and control by multiple parties. These fearful, frustrated, angry physicians may act out more frequently than before in the work place.
- Rapid changes in the health care delivery system have stressed many physicians.
- Many physicians have grown up in an abusive environment. In medical school they may have been the object of physical, verbal and mental abuse. This behavior by their teachers and mentors may have left an imprint on them. Not only was this behavior previously tolerated but it was seen as a mark of the abuser's position and genius.

- Medical training has emphasized intellectual capacity at the expense of fostering and teaching interpersonal skills.

There are times when a physician's conduct is so distressing to the operation of the hospital or the medical staff review process that the value of the physician's clinical work is outweighed by the negative impact of his or her behavior. Such unacceptable behavior can take many forms, including tirades in the operating room, abusive treatment of patients/employees, sexual harassment, or the disruption of meetings. In any case, TMF recommends using the less pejorative and more accurate phrase "distressed behavior" instead of "distressed physician" when medical staffs begin to confront the problem.

It is difficult to precisely define "distressed behavior," but it encompasses **a chronic pattern of contentious, threatening, intractable, litigious behavior that deviates significantly from the cultural norm of the peer group, creating an atmosphere that interferes with the efficient functioning of the health care staff and the institution**. The use of the word "chronic" in this definition implies a habitual pattern of behavior as opposed to the rare or occasional outburst on the part of the acutely fatigued or stressed physician, which is usually recognized even by the offending physician as exaggerated and inappropriate.

- The distressed physician often lacks the ability of self-observation:
- They view themselves as clinically superior (and they often are).
- They view other members of the health care team as less competent or incompetent weak and vulnerable.
- They view themselves as champions for their patients (view often shared by patients).
- Their distressed behaviors are used either consciously or subconsciously to intimidate, control and blame others (for bad results). They are unable to perceive that the victims feel harassed, manipulated, controlled and abused.
- They feel misunderstood and the object of envy and jealousy by others when confronted.

Their actions cause:

- A decrease in morale.
- Increase in the level of workplace stress.
- Inordinate time spent by staff appeasing or avoiding them.
- Increased risk for errors - communication breakdown that can result in delays and mistakes in making and implementing critical medical decisions.
- Increased potential for malpractice litigation.

Distressed conduct is more than unusual or unorthodox behavior. It typically involves a pattern of behavior characterized by one or more of the following actions:

1. **Inappropriate anger or resentment**

- Intimidation
- Abusive language
- Demeaning other staff
- Blaming or shaming others for possible adverse outcomes
- Unnecessary sarcasm or cynicism
- Threats of violence, retribution or litigation

2. Inappropriate words or actions directed toward another person

- Sexual comments, jokes or innuendo
- Flirtation, sexual harassment
- Seductive, aggressive or assaultive behavior
- Racial, ethnic or socioeconomic bias or slurs
- Lack of regard for personal comfort and dignity of others

3. Inappropriate responses to patient needs or staff requests

- Uncooperative, defiant, rigid, inflexible
- Avoidant, unreliable
- Late or unsuitable replies to pages and calls or exaggerated response
- Unprofessional demeanor or conduct
- Arrogant, disrespectful
- Inadequate communication in quantity, quality and promptness
- Recurrent conflict with others, particularly authority figures; irrational, oppositional

Some specific examples include:

- Employs threatening or abusive language directed at nurses, hospital personnel, or other physicians (e.g. belittling, berating, and/or threatening). These attacks usually are personal, irrelevant, and go beyond the bounds of fair professional comment.
- Makes degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital. The physician's non-constructive criticism often works to intimidate, undermine confidence, belittle, or imply stupidity or incompetence in his or her victims.
- Uses profanity or other grossly offensive language while in a professional setting. Refuses to accept medical staff assignments or participate in committee or departmental affairs on anything but his or her own terms.
- Utilizes threatening or intimidating physical contact.
- Makes public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital.
- Writes inappropriate medical records entries concerning the quality of care being provided by the hospital or any other individual. (One may find illustrations in patient medical records, or other official documents. These

communications are designed to impugn the quality of care in the hospital or attack particular physicians, nurses.)
- Imposes idiosyncratic requirements on ancillary staff which have nothing to do with better patient care, but serve only to burden staff with "special" techniques and procedures.

Note that we are talking about a pattern of behavior that may or may not overlap a psychiatric diagnosis and/or other impairment such as chemical dependence, major depression or personality disorder. The presence or absence of a diagnosis is important for many reasons, including the ability of the TMF PHP to help. The presence of a pattern is also very important. The TMF PHP usually does not (and generally should not) receive referrals for an isolated incident or very minor instances of distressed behavior.

A hospital is an especially stressful working environment, so outbursts or other misconduct that probably would not be tolerated elsewhere are often excused. If an isolated outburst is followed by an apology, there is most likely not a longer-term problem. There are clearly limits to tolerance, however. When a physician's conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other physicians on the medical staff, or begins to interfere with the physician's own ability to practice competently, action must be taken.

Common Causes of Distressed Behavior

Chemical dependence: Hidden or occult substance abuse may cause significant distress and dysphoria and present as distressed behavior. If the chemical dependence is treated and the individual is subsequently involved in ongoing therapy, their entire personality can improve. However, sometimes substance use or abuse is just a coincident problem and not the cause of the distressed behavior.

Medical problem(s): While medical problems are not usually the cause of distressed behavior, other PHPs around the country have encountered poorly controlled diabetes, Cushings disease, and undiagnosed CNS tumors causing personality and behavior changes. If medical problems are a factor, there will often be an acute change in behavior or personality. Sleep deprivation/fatigue: This is usually due either to the consequences of the behavior (e.g. threatened loss of privileges, etc.), or related to overwork and other self-care issues. In other words, sleep problems are more of a symptom than a cause.

Adjustment disorder: Marital, financial, family, legal and other stresses are often found in conjunction with distressed behavior. Personal stress tends to exaggerate pre-existing personality traits, and it's typically not the healthy traits that blossom! Physicians referred to TMF PHP for distressed behavior often will minimize underlying stress, or say they have "already dealt with it." Unfortunately, life has a way of presenting new and recurrent stresses, and the development of healthy coping skills is necessary.

Personality disorder (or traits): The American Psychiatric Association's Diagnostic and Statistical Manual – Fourth Edition (DSM-IV) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" manifested in the person's cognition, emotional response, interpersonal relations and/or impulse control. Personality traits are those noticeable characteristics that do not rise to the level of a personality disorder. Obviously, we all have some pathological personality traits, and the line between "healthy" and "unhealthy" is often fuzzy.

The DSM lists 10 distinct personality disorders. The ones most commonly associated with distressed behavior are:

- Obsessive-Compulsive
- Narcissistic
- Borderline
- Schizoid
- Paranoid
- Antisocial

The two most frequently encountered are Obsessive-Compulsive and Narcissistic.

Obsessive-Compulsive (O-C): It can be very difficult to agree on what is acceptable vs. unacceptable behavior. At one end of the spectrum is the individual who is extremely rigid, domineering, stubborn, and so focused on getting the details perfect that they miss the major goal of the activity. The perfectionism interferes with task completion, and the O-C doctor will typically run way behind schedule or be hopelessly behind on documentation. They need to be in control and have trouble delegating tasks.

At the other end of the spectrum is the physician who is appropriately compulsive about patient care. All patients want their surgeon to be detail-oriented in the operating room, or their internist to be compulsive in doing a work-up for disease. Indeed, medicine is increasingly rule-driven, and the consequences of not being appropriately compulsive are steadily rising. The key is in the word "appropriate." The distressed O-C physician typically has trouble accepting input from anyone else as to what is appropriate, and almost always has problems in working out differences of opinion. They tend to avoid their anxious feelings through control and action rather than using introspection or diplomacy. Therefore, development of awareness, tolerance, and alternate coping skills for anxiety is crucial.

Narcissistic:
Many would say that the phrase "narcissistic physician" is redundant. Indeed, physicians are trained and expected to be confident in their abilities, and to forego self-doubt in times of crisis. The trick is to avoid what has been called the "M-Deity syndrome", or pathologic narcissism. DSM-IV criteria for Narcissistic Personality Disorder includes:

- Arrogance or "condescending superiority"
- Exaggerated sense of achievements and talents

- Lack of empathy
- Craving for admiration
- Strong sense of entitlement

In addition, the pathologically narcissistic physician often is intolerant of imperfection (or perceived imperfection) in others. As with all personality disorders, narcissism has its origin early in life. Parents may set unrealistically high standards for the child who begins to think of him or herself as "special." The parents typically are unable to emotionally nourish the child, and provide harsh criticism for failure. The child internalizes these attitudes and later is unable to empathize with others, etc. Otto Kernberg characterized the unconscious dynamic as: "I am grandiose because I feel unlovable; I cannot be loved unless I am perfect." While these underpinnings of the disorder do not excuse the problems, insight into the narcissist's deep-seated feelings of inadequacy can help the person begin to change behavior over the long term.

Hospital Management of the Distressed Physician

Each hospital should have **bylaws** in place. The recommendation is that each medical staff and hospital crafts its own bylaws in consultation with an attorney. Bylaws must emphasize the hospital's right to impose sanctions up to and including dismissal.

The second preparatory measure is the development of a clear corporate **policy** defining behaviors which are unacceptable. These policies, rules and regulations should be presented to all hospital employees and medical staff both in written form and in an ongoing series of educational seminars.

There should also be training in **documentation** of the unacceptable behaviors. Documentation should include:

- Time and place of the occurrence.
- Detailed factual description of the behavior.
- Circumstances that precipitated the behavior.
- List of others who observed the incident.
- Consequences this behavior had on patient care and hospital operations.

This documentation is vital. Unlike medical mishaps which are usually well documented, these incidents may be poorly recorded and it is often the collection of multiple reports from many observers that eventually become grounds for remedial action.

Reporting incidents is most difficult because:

- It may have a marked impact on the physician's career.
- It needs to be understood that reporters will be protected.
- The hospital itself may be reticent to interfere because of a desire to avoid unpleasant, possible litigious, confrontation. Some hospitals find themselves in

an economic bind where the distressed physician is a high volume admitter or the only practitioner of his/her specialty.

After the event has occurred, there should be an established progressive series of **interventions**. Depending on the seriousness of the occurrence, the initial intervention should be performed by two or more senior members of the staff and administration in order to establish:

- The seriousness of the situation.
- That this represents a unified group decision.

Before the intervention occurs, a clear set of goals should be agreed upon. The intervention should allow for the following:

- To occur in a private, quiet, neutral setting - so both parties can leave when the intervention is finished.
- Have sufficient time allotted.
- Assure the physician of privacy and confidentiality.
- Information should be presented in a clear non-judgmental, empathetic manner.
- It should consist of specific, factual data. This information should be related to how it interfered with patient care and hospital function.
- Help should be offered.
- Carefully and clearly state that the physician will be closely monitored to ensure that the behavior or similar behavior does not recur.
- Explanation of consequences for failure to change behavior.

The proceedings of the meeting should be fully documented. A copy of the minutes should be part of the physician's personnel file.

Recommendations for Action

Whatever hope a hospital medical staff may have for moderating a distressed physician's behavior will be best realized by addressing the problem immediately, before the attitudes of either party have hardened and while it is still possible that the matter is capable of collegial resolution. Certainly, this is so for the physician, but it is also true for the hospital and medical staff leaders. If the physician knows that his or her conduct is unacceptable and that the hospital and medical staff leaders are prepared to act, future incidents may be prevented.

However, just as surely as it is wise to address behavior problems as soon as they occur, it is also wise to do so with caution. Confronting the physician in a heavy-handed, accusatory manner is likely to invite resentment and possible retaliation. The initial approach should be undertaken as a helpful gesture. At the same time, it must be made clear that it is more than a difference of opinion; that is, if the behavior continues, more formal action will be taken to stop it.

Following are some actions which can be taken by hospital medical staffs to deal with the distressed physician:

1. Focused education dealing with the following areas:
    - Anger management
    - Conflict resolution
    - Sensitivity training skills
    - Communication
    - Behavioral modification: positive and negative incentives
    - Impulse control training

2. Peer monitoring
3. Leave of absence
4. Partial loss of privileges
5. Temporary suspension of privileges with a clear plan and requirements for re-entry
6. Suspension of privileges
7. Revocation of privileges
8. Denial of appointment or reappointment

If the Chief of Staff is reluctant to meet with the physician or if, for any other reason, the Chief of Staff or the Chief Executive Officer determines it to be appropriate, the Board Chairperson or another Board member could meet with the physician.

Having a Board member meet with the physician has several advantages. It relieves the Chief of Staff of a responsibility for which he or she may have neither the taste nor the experience. And when a physician understands that he or she is accountable directly to the Board for his or her conduct, it may be easier to correct the situation in an informal manner. Alternately, if the physician perceives that he or she would be bending to the wishes of other physicians in matters that the physician considers none of their business, it may be more difficult to correct.

Addressing distressed conduct immediately will also strengthen the hospital's position if the physician subsequently challenges the disciplinary action in court. A hospital will want to limit the number of participants in any meeting with the physician, not only to minimize the doctor's feeling that he or she has been the object of widespread discussion, but also to limit the targets of any attempts at retaliation.

The record should not be a catalog of ineffective oral warnings, however. A hospital medical staff will protect itself by following up the warning(s) with written letters to the physician. These writings help to create a record showing that the medical staff made reasonable attempts to deal with the problem, short of terminating the physician's medical staff appointment and clinical privileges. This written record also prevents a physician's later claims that no one had ever discussed with him or her the distressed behavior in question.

It does not require medical expertise to determine whether as a qualification for appointment a physician possesses the ability to "work harmoniously with others…." A recommendation from the Medical Executive Committee (or any other medical staff committee) is not necessary in these situations and should not be required.

The TMF drafted this document with an eye towards ensuring necessary flexibility for dealing with these situations without immobilizing the medical staff or hospital administrative staff. This allows the Medical Executive Committee to refer these matters to the Board without recommendations. However, the Medical Executive Committee may handle the matter.

If the hospital follows the procedure either through the Medical Executive Committee or the Board and it is inherently fair and compliant with the staff bylaws, and there is a well-documented record of the physician's conduct and the hospital's attempts to deal with it, then in all likelihood the hospital's action will be upheld should the matter proceed to litigation. There are many court decisions upholding hospitals' disciplinary actions when confronted with a physician's distressed conduct. The courts have made it abundantly clear that the provision of patient care in an atmosphere of calm, order and respect for the dignity of all need not be sacrificed to the distressed proclivities of any appointee to the medical staff, regardless of his or her clinical abilities.

No matter what action is taken, medical staffs should work with their legal counsel to address any required follow-up reporting to state and federal agencies. Please note that:

- Any change in privileges may be reportable to the state licensing board (for MD physicians, the Board of Medical Examiners (BME); for DO osteopathic physicians, the Board of Osteopathic Examination).
- Sanctions or other changes to a physician's privileges that last for longer than 30 days are reportable to the National Practitioners Data Bank. [See 42 USC §11133.]

When can the TMF PHP be of help?

The distressed physician is a medical staff issue. Referral to the TMF PHP is appropriate only when corrective action has been taken by the hospital staff and has failed. The hospital or group must be willing to impose consequences.

The TMF PHP serves to advise medical staffs regarding resources available for corrective action. It is beyond the scope of the TMF PHP to do any assessments or to take corrective action.

Legal Considerations

At least one court has held that hospitals have a duty to take action in such situations. In Leach v. Jefferson Parish Hospital District, No. 2, 870 F.2d 300 (5th Cir. 1989), the Fifth Circuit Court of Appeals stated, "... the hospital clearly has an interest in providing quality medical care to its patients. If a physician is distressed or has personal problems, the hospital has a duty to intervene."

The first step in dealing with professional conduct is to implement a policy that makes the hospital's position clear.

Summary

- Distressed behavior by a physician may or may not relate to a psychiatric diagnosis.
- The hospital, clinic, or other referring entity should be prepared to impose consequences if the behavior continues unchanged. While it may be appropriate to "cut some slack" if the physician is working on underlying issues, few work settings will tolerate unabated distressed behavior for long.
- The physician with distressed behavior is often unaware of their effect on others. It is common for the physician themselves to be only vaguely aware of "a small problem," while nurses and other physicians around them are busy preparing their resumes.

Additional Points

- It's crucial to have appropriate expectations. The causes of distressed behavior do not develop overnight, and it's unrealistic to expect the physician to change his or her behavior overnight with no slip-ups. That's one reason it is important to address the behavior before the environment reaches the point of "zero tolerance" for minor infractions.
- The physician with distressed behavior is often a technically excellent clinician. However, their self-assessment often exceeds reality.

TMF TENNESSEE MEDICAL FOUNDATION

For more information or assistance, contact the TMF Physician's Health Program at 615-467-6411 or visit www.e-tmf.org.

Struggling?

IF YOU OR SOMEONE YOU KNOW IS DEALING WITH...

- Stress/Burnout
- Depression
- Anxiety
- Substance Use
- Anger
- Impulsive Behavior
- Relationship Issues
- Conflicts at Work

We are here to help.

Don't wait until an issue is career or life threatening. Call the TMF Physician's Health Program. We are your confidential resource for help, hope, and healing.

615-467-6411

TMF
TENNESSEE MEDICAL FOUNDATION

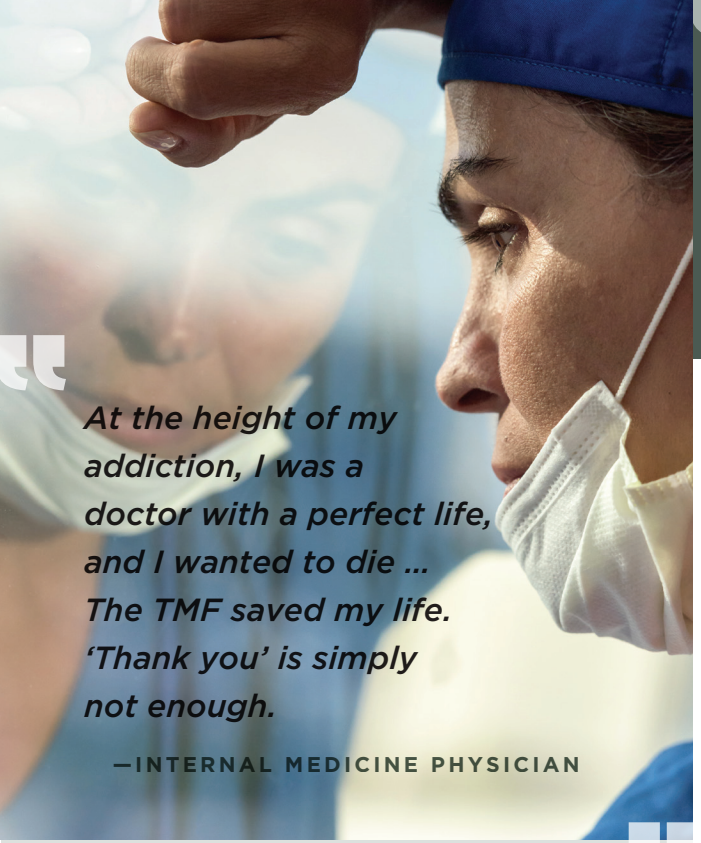
Saving Lives. Saving Careers.

5141 Virginia Way, Ste. 110
Brentwood, TN 37027

e-tmf.org

Poster funding provided by KAMA
KNOXVILLE ACADEMY OF MEDICINE ALLIANCE

Suggestion: Hang this in your doctor's lounge or medical staff break room.



At the height of my addiction, I was a doctor with a perfect life, and I wanted to die … The TMF saved my life. 'Thank you' is simply not enough.

—INTERNAL MEDICINE PHYSICIAN

CONTACT US

Don't wait until an issue is career or life threatening. Call the TMF if you or someone you know is struggling or in crisis. We are your confidential resource for help, hope, and healing.

In addition to the assistance offered through the Physician's Health Program, the TMF provides resources and educational training that can help Tennessee's licensed health professionals maintain a healthy and balanced lifestyle. Visit our website to learn more.

(615) 467-6411
e-tmf.org

I have seen firsthand the miracle that the TMF and its physicians and employees perform on a daily basis. The program works.

—TMF SUPPORTER/VOLUNTEER

HELP US

Since 1978, the Tennessee Medical Foundation (TMF) Physician's Health Program (PHP) has served doctors and other health professionals, hospitals, and communities throughout Tennessee.

Today, we continue to provide expert, confidential assistance that addresses health concerns specific to physicians and other medical professionals across the state. To do our work, we rely on financial support from donors like you. Please help us provide the services and support our participants need to recover from addiction, mental or emotional illness, and restore them to life and healthy practice.

JOIN WITH US AS WE PROVIDE A LIFELINE FOR OUR TENNESSEE HEALTH PROFESSIONALS!

The TMF is a 501(c)3 organization.

TMF
TENNESSEE MEDICAL FOUNDATION

5141 Virginia Way, Ste 110
Brentwood, TN 37027
615-467-6411 | e-tmf.org

TMF
TENNESSEE MEDICAL FOUNDATION

SAVING LIVES. SAVING CAREERS.
e-tmf.org

OUR MISSION

The mission of the TMF Physician's Health Program (PHP) is to protect patients through identification, intervention, rehabilitation and the provision of advocacy/support for physicians impaired by addictive disease, mental or emotional illness.

The TMF treated me like I was sick, not bad, and they continue to treat the addicted physicians in the state of Tennessee that way today. By staying involved with the TMF I get to see miracles happen and that means the world to me.

—PAST PARTICIPANT

OUR FOCUS

We expect a lot from our health professionals. They are constantly under pressure to perform and when making decisions that affect the health and well-being of their patients, there is no room for error. However, they are human, too. Like everyone else, they can succumb to burnout/stress, addiction, emotional or mental illness, and behavioral issues. The difference is their problems can directly impact the safety of their patients. Fortunately, the TMF Physician's Health Program (PHP) exists to address health concerns that are specific to health professionals, while working to protect the safety of patients in Tennessee.

We work with many Tennessee health professionals, both licensed and in training: physicians (MDs and DOs), physician assistants, optometrists, podiatrists, veterinarians, chiropractors, and x-ray technicians.

WE HELP WITH:

- Alcohol and Drug Dependency
- Disruptive Behavior
- Boundary Issues
- Psychiatric Disorders
- Burnout/Stress
- Cognitive Deficits
- Other Behavioral Illnesses

OUR PROCESS

1 IDENTIFICATION

The process begins when an employer, family member, patient, or co-worker confidentially reports concerns about a health professional. Self-reporting by the professional is also encouraged.

2 VERIFICATION

The TMF-PHP medical director and/or case managers attempt to verify the reported behavior. If the behavior is not verified, the process is halted or the information is held for further inquiry.

3 INTERVIEW

The referred professional is asked to make an appointment for an interview with the TMF-PHP medical director. In exchange for support, the professional is invited to follow the recommendations of the TMF in seeking specified evaluation/treatment at his or her own expense.

4 EVALUATION/TREATMENT

Evaluation/treatment is carried out in facilities vetted and approved by the TMF. Professionals affected by other emotional or behavioral conditions are treated with an initial evaluation and subsequently prescribed inpatient and/or intensive outpatient therapy.

5 RE-ENTRY

Re-entry into practice usually occurs in the week following treatment. During this period, the TMF is often the professional's strongest – and sometimes only – ally. The medical director and case managers work in concert with the treatment center's recommendations to establish contractual ground rules for re-entry into practice.

6 AFTERCARE

Aftercare is usually a five-year process. It is guided by an individualized monitoring agreement, comprised of recommendations from the treatment facility. The TMF offers guidance and accountability in the recommended aspects of each participant's recovery.

West Virginia Medical Professionals Health Program

SINCE 2007

INITIATING THE PROCESS

Phone call or email

EXCLUSION CRITERIA

Case by case

FORMAL INTERVENTION OFFERED

Yes

ASSESSMENT

Provided 3 referrals

TESTING

Agency: FSSolutions
Frequency: Weekly for first year or two, then twice monthly thereafter

REQUIRED MEETINGS

Three 12 Step meetings per week
90 in 90 if alcohol
Weekly caduceus meetings

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Frequent contact via email and phone, face to face meetings at least a couple of times during participation (office & offsite)

CHEMICAL RELAPSES

Level system

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Level system

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary, (may not practice)
Buprenorphine: Case by case basis (work with prescriber)
Medical Marijuana: No
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Families of physicians
Medical students
Residents
Podiatrists
Physician assistants

LENGTH OF MONITORING

1 to 2 years for mild SUD, 5 years for moderate to severe SUD

APPROXIMATE FEES

$50-$200 depending on profession

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Board requires quarterly report

STAFF

P. Bradley Hall, MD, DABAM, FASAM, MRO,
Executive Director

1 Associate Medical Director
1 Administrator
1 Case Manager

FUNDING SOURCES

Hospital contributions (35%)
Participant fees (25%)
Licensing fees (40%)

OF ACTIVE PARTICIPANTS

80
95% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

90% Completion rate
10%-15% Relapse rate
80% Return to work rate

NO ADDITIONAL INFORMATION AVAILABLE

Iowa Physician Health Program

SINCE 1996

INITIATING THE PROCESS

Phone call or walk-in

EXCLUSION CRITERIA

None

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

Provided 3 referrals

TESTING

Agency: RecoveryTrek
Frequency: Weekly for first 6 months, then varies

REQUIRED MEETINGS

Varies based on assessment and treatment

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Staff goes out to meet with participants once a year, every other year. On the alternate years, they meet with the Committee at the office

CHEMICAL RELAPSES

Required reassessment, and asked to stop working

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Tiered response

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case (with evaluation)
Opioids: Only when medically necessary (may be able to practice)
Buprenorphine: Yes (taper not required)
Medical Marijuana: No protocol yet, haven't had a case
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D.
Physicians – D.O.
Residents
Acupuncturists
Genetic Counselors

LENGTH OF MONITORING

Case by case; mild SUD is typically 3 years, moderate to severe is 5 years

APPROXIMATE FEES

Free

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Yes, if compliant

STAFF

Amy Van Mannen, LBSW, Project Manager

1 Case Manager

FUNDING SOURCES

All funding comes from the state licensing agency – budget is $250,000

OF ACTIVE PARTICIPANTS

42
81% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

No meaningful tracking system

Table of Contents

Self-Report Form

Complete the form and return to IPHP staff.

400 SW 8th Street, Suite C, Des Moines, IA 50309

Phone: 515-281-6006 Fax: 515-242-0155

www.iphp.iowa.gov

NAME:

CONTACT INFORMATION

Home Address & Phone:

Employer Name, Address & Phone:

Cell Phone #:

Email:

Which phone number do you prefer we use?

Home ☐ **Work** ☐ **Cell** ☐ **Other**

Can we leave messages for you at your preferred phone number? **YES** ☐ **NO** ☐

Can we communicate with you using the above email address? **YES** ☐ **NO** ☐

SELF-REPORT DETAILS

General reason for self-report (check all that apply):

Mental Health ☐ **Substance Use** ☐ **Physical Condition** ☐ **Disruptive Behavior** ☐

Other ☐

Have you undergone an evaluation for your condition? **YES** ☐ **NO** ☐ **N/A** ☐

If yes, list the name/location of the evaluation site.

Have you received treatment for this condition? **YES** ☐ **NO** ☐ **N/A** ☐

Who is/was your treatment provider(s)?

Date(s) & Location of Treatment:

Are you currently working or on a leave from your employment?

Do you supervise a physician assistant? **YES** ☐ **NO** ☐

Details of the event or situation that led to the self-report:

Licensees or applicants may be ineligible to participate in the IPHP for the following reasons:

- **Has engaged in the unlawful diversion or distribution of controlled or illegal substances for personal gain or profit.**
- **Is currently under an IBM order for alcohol or dug abuse or for another issue related to impairment.**
- **Has caused harm or injury to a patient.**
- **Board is currently investigating the applicant or licensee for matters related to an impairment.**
- **Has provided inaccurate, misleading or fraudulent information or failed to cooperate with the board or IPHP.**

Do any of the above apply to you? YES ☐ NO ☐

All information in possession of the IPHP & its personnel regarding licensees is confidential. Do you give the IPHP permission to inquire about the material facts you have provided in this self-report? YES ☐ NO ☐

SIGNATURE: **DATE:**

IOWA PHYSICIAN HEALTH PROGRAM

The Iowa Physician Health Program (IPHP) was established in 1996 to support physicians who self-report mental health issues, physical disabilities or substance use disorders. The advocacy and confidential monitoring program is administered by the Iowa Physician Health Committee, which is appointed by the Board of Medicine. Participants sign contracts agreeing to adhere to the strict guidelines. The program's overarching goals are supporting physicians who seek the program's assistance, protecting the public by carefully monitoring physicians with diagnosed impairments that may affect their abilities to practice, and maintaining credibility with the Board and the public by accountability and responsible application of authority. The committee and program are defined in Iowa Administrative Code 653 Chapter 14. Committee members receive a per diem and expenses.

The committee held four meetings in 2016 and met with 27 program participants. Staff members conducted field visits with 16 participants. The program's budget of $213,141 in FY2018 is funded entirely with licensure fees. Licensees do not pay additionally to participate in the program, but they are responsible for all costs associated with drug screening, therapy, treatment and so forth.

Staff members of the Board manage the program and meet with the participants in the field to ensure compliance. The committee's co-chairs and legal counsel provide guidance on case issues. **Members of the committee in 2017:**

- Lester Yen, M.D., West Des Moines, co-chair
- Raymond Harre, M.D., Davenport, co-chair
- Eric Boyum, M.D., Oskaloosa
- Kim Brangoccio, LMFT, CEAP, IAADC, Booneville
- Jeanine Freeman, J.D., Des Moines
- Jeff Kerber, Ph.D., West Des Moines, licensed marriage and family therapist
- Sasha Khosravi, D.O., Grimes
- Jeffrey Means, M.Div., Ph.D., Des Moines
- Mark Bowden, M.P.A., executive director, Board of Medicine

Amy Van Maanen, L.B.S.W., is the program's coordinator and Emily Zalasky, L.B.S.W., is the program's case manager. Sara Scott, an Assistant Iowa Attorney General, provides legal counsel for the program and the committee.

IOWA PHYSICIAN HEALTH PROGRAM | http://iphp.iowa.gov/

(TOTALS ON DECEMBER 31)	2016	2017
Active Participants	**50**	**45**
In review for eligibility	**8**	**13**
Physicians	**47**	**49**
Resident physicians	**11**	**8**
Discharged	**37**	**37**
Noticed for violations	**5**	**4**

(PARTICIPANTS' DIAGNOSES)	2016	2017
Substance use	**13**	**11**
Mental health	**8**	**7**
Physical condition	**2**	**1**
Multiple diagnoses	**27**	**25**

MINNESOTA HEALTH PROFESSIONALS SERVICES PROGRAM

SINCE 1993

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

None

FORMAL INTERVENTION OFFERED

No

ASSESSMENT

If already in treatment, no assessment; otherwise provided 3 referrals

TESTING

Agency: Local certified lab
Frequency: 9 screens per quarter for first 2 years, then 6 per quarter

REQUIRED MEETINGS

Typically includes weekly 12 Step meetings and caduceus meetings

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Case by case basis; typically when non-compliant, but not necessarily. Meetings take place in the office.

CHEMICAL RELAPSES

Required reassessment, and asked to stop working

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Tiered response

CONTROLLED SUBSTANCES

Benzodiazepine: Case by case (with assessment)
Stimulant: Case by case (with assessment)
Opioids: Only when medically necessary (may be able to practice)
Buprenorphine: Yes (taper not required)
Medical Marijuana: No
Recreational Marijuana: N/A

PROFESSIONS SERVED

Physicians – M.D./D.O.
Dentists
Residents
Psychologists
Podiatrists
Nurses
Physician assistants
Pharmacists
Veterinarians
Other

LENGTH OF MONITORING

Mild SUD: 1 year
Moderate to severe SUD: 3 years
Diversion or anesthesiologist: 5 years

APPROXIMATE FEES

Free

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: Yes, if compliant

STAFF

Monica Feider, MSW, LICSW, Program Manager

2Case Managers
2 LADCs

FUNDING SOURCES

Legislature
Professional boards

OF ACTIVE PARTICIPANTS

600
50% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

50%-68%, but they also include referrals to the Board as success

Table of Contents

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-642-0487 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

Participant Signed Acknowledgement

******Complete and return this form to HPSP******

This form is provided to you in conjunction with the Toxicology Screening Instructions. After reviewing the document, complete and return this form to HPSP with your signed Participation Agreement or as otherwise requested.

As part of HPSP's toxicology screening process, I agree to:

1) **Register with Hennepin County Medical Center (HCMC)**

Complete and return the tan attached ***HCMC Account Generation*** form to HPSP (page 11).

2) **Establish a Collection Site**

I will provide my urine specimens at the following preapproved sights (check all that apply):

☐ HCMC ☐ Mayo EHS (Rochester)* ☐ Park Nicollet EHS* ☐ Methodist EHS*

**Participants must be employees and should contact employee or occupational health programs to register prior to providing specimens*

OR

I will provide my urine specimens at:

☐ Other - If choosing this option, provide the attached ***Collection Site Protocols Agreement*** form (page 12) to the proposed collection site. The proposed collection site must complete and return a copy of the form to HPSP. The proposed collection site(s) is: _____

Additional Collection Site Protocols Agreement forms can be found on HPSP's website at: https://mn.gov/boards/hpsp/toxicology/.

I have read and understand the information provided in the Toxicology Screening Instructions and I authorize HPSP to communicate with my specimen collectors and lab regarding the collection or screening processes or results.

_____	_____	_____
Print Name	**Signature**	**Date**

Thank you for your continued cooperation.

Health Professionals Services Program

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-642-0487 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last			**DOB:**
Provider:	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As an enrollee or participant in the Health Professionals Services Program (HPSP), you are being asked to authorize HPSP to obtain data for the purposes of determining your eligibility for HPSP services, to establish and implement a Participation Agreement, and to provide ongoing monitoring services. You are not legally obligated to release this information to HPSP; however, if you fail to release the information, HPSP will discharge you and make a report to your regulatory board.

INFORMATION TO BE DISCLOSED BETWEEN HPSP AND THE ABOVE IDENTIFIED PROVIDER:

Medical History, Assessment, Treatment and Status	X	Verbal Exchange of Information	X
Mental Health History, Assessment, Treatment and Status	X	Progress Notes/Continuing Care Plan	X
Substance Use History, Assessment, Treatment and Status	X	Work Quality or Ability	X
Monitoring Data	X	Toxicology Screen Results	X
Quarterly reports about: diagnoses; continuing care; treatment compliance and progress; work ability; and work quality			X

Classification of data subject to Minn. Stat.

HPSP DATE STAMP

I UNDERSTAND THAT:

- This authorization expires at the end of one year from the date of consent, unless expressly removed in writing earlier.
- I may revoke this authorization at any time by notifying HPSP and the providing individual/organization in writing, and it will be effective on the date notified except for information that has already been released under this authorization.
- The information provided to HPSP may be accessible to HPSP medical consultants and other providing organizations authorized to exchange information.
- The information provided will be forwarded to the appropriate regulatory authority if I: a) fail to meet HPSP admission criteria; b) violate the terms of my Participation Agreement; c) leave or am discharged from the program except upon fulfilling the terms for successful completion of the program as set out in the Participation Agreement; d) cause patient harm; e) unlawfully substitute or adulterate medications; f) write a prescription in the name of a person or animal for my personal use; g) alter a prescription without the knowledge of the prescriber for the purpose of obtaining the drug for personal use; h) unlawfully use a controlled or mood altering substance or use alcohol while providing patient care or during a period of time in which I may have been contacted to provide patient care or is otherwise on duty; or i) if there are allegations I have been committed violations of my practice act that are outside the authority of HPSP.
- HPSP may release data to other persons and government entities who are authorized to review data, investigate specific conduct, or take other legal action.

PARTICIPANT SIGNATURE: _____ **DATE**: _____

Health Professionals Services Program

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-642-0487 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last			**DOB:**
Party: Work Site Monitor/Employer	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As an enrollee or participant in the Health Professionals Services Program (HPSP), you are being asked to authorize HPSP to obtain data for the purposes of determining your eligibility for HPSP services, to establish and implement a Participation Agreement, and to provide ongoing monitoring services. You are not legally obligated to release this information to HPSP; however, if you fail to release the information, HPSP will discharge you and make a report to your regulatory board.

INFORMATION TO BE EXCHANGED BETWEEN HPSP AND THE ABOVE IDENTIFIED PARTY:

Quarterly reports about work ability and work quality	X	Toxicology Screen Results	X
Work quality and ability	X	Verbal Exchange of Information	X
Fitness for duty evaluations	X	Other (specify)	
Monitoring requirements and data (diagnosis, work restrictions, monitoring compliance)			X

HPSP DATE STAMP

Classification of data subject to Minn. Stat.

I UNDERSTAND THAT:

- This authorization expires at the end of one year from the date of signature unless expressly removed in writing earlier.
- I may revoke this authorization at any time by notifying HPSP and the providing individual/organization in writing, and it will be effective on the date notified except for information that has already been released under this authorization.
- The information provided to HPSP may be accessible to HPSP medical consultants and other providing organizations authorized to exchange information.
- The information provided will be forwarded to the appropriate regulatory authority if I: a) fail to meet HPSP admission criteria; b) violate the terms of my Participation Agreement; c) leave or am discharged from the program except upon fulfilling the terms for successful completion of the program as set out in the Participation Agreement; d) cause patient harm; e) unlawfully substitute or adulterate medications; f) write a prescription in the name of a person or animal for my personal use; g) alter a prescription without the knowledge of the prescriber for the purpose of obtaining the drug for personal use; h) unlawfully use a controlled or mood altering substance or use alcohol while providing patient care or during a period of time in which I may have been contacted to provide patient care or is otherwise on duty; or i) if there are allegations I have been committed violations of my practice act that are outside the authority of HPSP.
- HPSP may release data to other persons and government entities who are authorized to review data, investigate specific conduct, or take other legal action.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

Health Professionals Services Program

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

Professional Support Group Attendance Form

NOTICE

- **You do not need to use this form if** you attend Physicians Serving Physicians (PSP), Pharmacists Recovery Network (PRN), Dentists Concerned for Dentists (DCD) in Minneapolis, or the Health Professionals Group at the Mayo Clinic. The group facilitators will provide HPSP with documentation of your attendance.
- **You need to use this form if** you are required to attend health care professional mutual support group meetings other than those listed above.

PARTICIPANT – PRINT YOUR NAME: _____

Please check quarter date: January 15th ☐ April 15th ☐ July 15th ☐ October 15th ☐

Ask group leader or member to document your attendance below:

Meeting Name or Location	*Signature/Initial of Group Leader or Member*	*Meeting Date*

Please return completed form to:

HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 – or **Fax** to 651-643-2163

Report forms are available at mn.gov/boards/hpsp/

THANK YOU!

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

Mutual Support Group Meeting Attendance Form

NOTICE

- You are required to document your attendance at mutual support group meetings and to have regular contact with your sponsor.
- You may document your mutual support group attendance by having someone sign this attendance sheet at each meeting you attend and sending it to HPSP at the end of each quarter ***OR*** by having your sponsor complete and return the Mutual Support Group Sponsor Form to HPSP at the end of each quarter, unless your case manager requires both.

PARTICIPANT - PRINT YOUR NAME: _____**DOB:**_____

Please check quarter date: January 15th ☐ April 15th ☐ July 15th ☐ October 15th ☐

Ask group leader or member to document your attendance below:

Meeting Date	*Meeting Location*	*Signature or Initials of Group Leader or Member*

Meeting Date	*Meeting Location*	*Signature or Initials of Group Leader or Member*

Please return completed form to:

*HPSP, 1380 Energy Lane, Suite 202, St. Paul, MN 55108 or **Fax** to 651-643-2163*

Report forms are also available at mn.gov/boards/hpsp/

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120/ fax: 651-643-2163
website: mn.gov/boards/hpsp/

Mutual Support Group Sponsor Report Form

YOUR SPONSOR COMPLETES AND RETURNS THIS FORM TO HPSP

NOTICE

- You are required to document your attendance at mutual support group meetings and to have regular contact with your sponsor.
- You may document your mutual support group attendance by having your sponsor complete and return this form to HPSP at the end of each quarter ***OR*** by having someone sign a Mutual Support Group Attendance Form at each meeting you attend and returning it to HPSP at the end of each quarter, unless your case manager is requiring both.

PARTICIPANT - PRINT YOUR NAME: _____**DOB:**_____

Please check quarter date: January 15th ☐ April 15th ☐ July 15th ☐ October 15th ☐

SPONSOR COMPLETES ↓

SPONSOR signature or initial: **DATE:**
Meeting location:
Number of meetings attended together over last quarter:
To the best of my knowledge, participant attends #_____ meetings per week
To the best of my knowledge, participant has maintained sobriety: Yes ☐ NO ☐
Additional comments:

Please return completed form to:

*HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 or **Fax** to 651-643-2163*

Additional forms are also available at mn.gov/boards/hpsp/

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

MONTHLY MEDICATION LOG

Use this form to document your use of controlled substances & return it to HPSP after ending the prescription or at end of the month.

PLEASE PRINT

Participant Name: DOB:	Prescriber:
Reporting Month/Year:	Is the prescriber your primary care provider? Yes ☐ No ☐
Medication/mg:	If no to above, is your primary care provider aware of rx? Yes ☐ No ☐
Dosing Instructions:	Pharmacy Name:

Copy RX on file? Yes ☐ No ☐ *Provide HPSP with copies of prescriptions for all controlled substances, including refills, within 3 days of filling.*

Date	Time	#Taken	#Remain
1st			
2nd			
3rd			
4th			
5th			
6th			
7th			
8th			
9th			
10th			
11th			

Date	Time	#Taken	#Remain
12th			
13th			
14th			
15th			
16th			
17th			
18th			
19th			
20th			
21st			
22nd			

Date	Time	#Taken	#Remain
23rd			
24th			
25th			
26th			
27th			
28th			
29th			
30th			
31st			

- Use one form for each controlled substance.
- Ensure appropriate disposal of unused controlled substances.

Additional forms are available at mn.gov/boards/hpsp/

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

TREATMENT PROVIDER REPORT FORM

HPSP Participant Name: _____

Primary Treatment Focus: _____

Secondary Treatment Focus: _____

Symptoms (i.e.: current, chances, exacerbations, relapse?):

_____

Treatment Plan/Recommendations/Interventions:

_____

Client/patient insight:

_____

Please check quarter date:

Jan 15th☐ April 15th☐ July 15th☐ Oct. 15th☐

Number of visits in last quarter: _____

Medications:

_____

To the best of your knowledge, is the client/patient working in their licensed profession? Yes ☐ No ☐

To the best of your knowledge, has the client/patient changed jobs in the last three months? Yes ☐ No ☐

Please list recommended practice restrictions (if any):

_____

PLEASE PRINT
Agency Name: _____

_____

Provider Name: _____

Provider Signature: _____

Provider Phone Number: _____

Date: _____

Please note that treatment providers may complete this form or provide a copy of most recent clinic notes.

Please return completed form to: HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 – or **Fax** to 651-643-2163
Report forms are available at mn.gov/boards/hpsp/

THANK YOU!

2018-03-08 Treatment Provider Report Form

MINNESOTA HEALTH PROFESSIONALS SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

WORK SITE MONITOR REPORT FORM

Please check quarter date: Jan 15th☐ April 15th☐ July 15th☐ Oct. 15th☐

Print Participant Name:

Print Work Site Monitor Name (WSM):

Workplace: WSM Phone Number:

Professional relationship to monitored individual:

Please check appropriate box:	1 = Poor	2	3=Average	4	5 = High
Record keeping (timeliness/accuracy):	◯	◯	◯	◯	◯
Punctuality:	◯	◯	◯	◯	◯
Professional demeanor to clients/patients:	◯	◯	◯	◯	◯
Professional demeanor to colleagues/staff:	◯	◯	◯	◯	◯
Overall work quality:	◯	◯	◯	◯	◯

Have participant's responsibilities changes since the last quarter? Yes ☐ No ☐

If yes, please explain:

Does the participant appear to be practicing in a safe and competent manner? Yes ☐ No ☐

If no, please explain

Comments (provide additional documentation if you believe it would be helpful):

WSM Signature **Date**

Please return completed form to:
HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 – or **Fax** to 651-643-2163

Report forms are available at mn.gov/boards/hpsp/
THANK YOU!

MINNESOTA HEALTH PROFESSIONALS SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-643-2120 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

Information about Mutual Support Group Meetings

Statewide AA meeting finder: http://aameetinglocator.org/ Greater Minneapolis Intergroup: http://www.aaminneapolis.org/ Greater St. Paul Intergroup: http://aastpaul.org/ Buddhist Recovery: http://www.buddhistrecovery.org/	Narcotics Anonymous: http://na.org/ Cocaine Anonymous: http://ca.org/ Smart Recovery: http://www.smartrecovery.org/ Woman for Sobriety: http://www.womenforsobriety.org/

Information about Support Group Meetings for Health Professionals

NOTE: The following meetings are for all health professionals unless specified otherwise. *(Effective 11/10/17)*

ROCHESTER

Health Care Professionals Recovery Group
Contact: Dr. Michael Palmen at 507-269-6992 for more information and cost

Health Professionals Support Group
Location: Generose Building
Must Contact: Tom Allert at 507-284-7352 prior to starting and cost
Meets: Wednesdays, 4:00pm to 5:00pm and Thursdays, 2:30pm to 3:30pm

Health Professionals AA
Location: Calvary Episcopal Church, 111 – 3rd Ave SW (West of Mayo Bldg)
Meets: Thursdays, 6:45am (additional meetings held here)

MAHTOMEDI

Health Professionals AA
Location: St. Andrews Lutheran Church, 900 Stillwater Road
Meets: Thursdays at 7:00pm to 8:00pm

MINNEAPOLIS

Health Professionals Recovery Group
Location: Fairview Riverside, 2450 Riverside
Meets: Mondays in Dining Room E, 7:30pm

WAYZATA

Health Professionals AA
Location: The Retreat, 1221 Wayzata Blvd E
Meets: Tuesdays, 6:00pm to 7:00pm (north of main building)

FARGO, ND

Health Professionals
Location: Sanford Hospital, S University Dr Conference Room 1A-1
Contact: Barrie March: 701-866-8460
Meetings on:
2nd Tuesday of month, 7:30pm
4th Tuesday of month, 7:30pm

MULTIPLE LOCATIONS - NURSES

Nurse Peer Support Network (NPSN)
****Nurses only****
NPSN meetings held throughout Minnesota.
For locations and times, contact: 612-508-3709 or the NPSN website at: https://nursespeersupport.nonprofitoffice.com/index.asp?SEC=5A31A7A0-7F49-4FBF-A66B-BB0836175B5D&Type=B_BASIC

MINNEAPOLIS – DENTISTS

Dentists Concerned for Dentists (DCD)
****Dentists only****
Location: MN Dental Assoc. Conf. Room**,** 1335 Industrial Blvd
Contact: DJ Enga at 651-430-3383
Meets: 3rd Wednesday of month, 6:30pm

MINNEAPOLIS & BEMIDJI – PHARMACISTS

MN Pharmacists Recovery Network
****Pharmacists only****
Location: St. Luke's Episcopal Church, 4557 Colfax Ave S, Minneapolis
Contacts: Jim Alexander, RPh at 612-825-5533 or Carl B in Bemidji at 218-668-2829
Meets: Wednesdays, 7:30pm to 8:30pm

MINNEAPOLIS - PHYSICIANS

Physicians Serving Physicians (PSP)
****Physicians only****
Contact: Nancy Bauer at 612-362-3747 for information on meetings.

(Please help keep this list updated! Notify your case manager if you are aware of changes.)
Updated 8/8/2018

Online: Go to "Hazelden Social Community" at: www.hazelden.org/social, click on "Join Now/Create An Account." Once an account is created, click "Log In" then click on "Chat Now" in lower right corner and then select Meeting Room B (virtual room). This is open to all health professionals. You do not need to be a Hazelden graduate to participate. This meeting does not replace requirement to attend live meetings.

MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1380 Energy Lane, Suite 202
St. Paul, MN 55108
phone: 651-642-0487 / fax: 651-643-2163
website: mn.gov/boards/hpsp/

Participant Update

PRINT NAME: **DOB:**	**Quarter Ending:** Jan 15th ☐ April 15th ☐ July 15th ☐ Oct. 15th ☐
Address Change? ☐ No ☐ Yes *(please update)*	**Employment Change:** No ☐ or Yes ☐ *(please update)*
Effective Date:	Effective Date:
New Address:	Worksite Name:
City: State: Zip:	Proposed Work Site Monitor:
Phone Change? ☐ No ☐ Yes (*please update)*	Address:
☐ Home#	City: State: Zip:
☐ Pager#	Position:
☐ Cell#	Schedule / hours:

Describe current symptoms:

List continuing care/recovery activities:

Describe challenges and successes in home/social life:

Describe challenges and successes in employment:

Summarize future plans:

Signature _____ **Date** _____ / _____ / _____

Please attach additional sheets/notes as necessary and mail completed form to:
HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 or **FAX to (651) 643-2163**
Report forms are also available at mn.gov/boards/hpsp/

SOUTHWORTH ASSOCIATES IDAHO | INTERVENTIONS, CONSULTING, AND MONITORING | SINCE 1987

INITIATING THE PROCESS

Phone call

EXCLUSION CRITERIA

None

FORMAL INTERVENTION OFFERED

Yes

ASSESSMENT

Provided 3 referrals

TESTING

Agency: FSSolutions
Frequency: once per week then decreasing as participants progress

REQUIRED MEETINGS

AA (90 in 90 if alcohol)
Abstinent based meeting once per week

FREQUENCY & LOCATION OF MEETINGS WITH PHP STAFF

Quarterly in Boise

CHEMICAL RELAPSES

Case by case

NONCOMPLIANCE (NOT SUBSTANCE RELATED)

Requests for reductions (in frequency of testing, meetings, etc.) may be denied

CONTROLLED SUBSTANCES

Benzodiazepine: No
Stimulant: Case by case with evaluation (may not be allowed to practice)
Opioids: Only when medically necessary (may not be allowed to practice)
Buprenorphine: Rarely (may not practice)
Medical Marijuana: N/A
Recreational Marijuana: N/A

PROFESSIONS SERVED

All Idaho licensees

LENGTH OF MONITORING

5 years; may adjust based on diagnosis

APPROXIMATE FEES

Varies depending on profession (did not provide fees)

SAFE HARBOR

Non-mandated: Yes, if compliant
Mandated: No

STAFF

Ben Seymour, CADC, Program Coordinator

Mark Broadhead, MD, Medical Consultant

1 Liaison to Idaho Medical Association
1 Compliance Monitor
1 Quality Assurance and Data Advisor

FUNDING SOURCES

Southworth
Contracted with Board for partial funding

OF ACTIVE PARTICIPANTS

Was not able to provide
35% non-mandated

CAN PARTICPANTS RETURN TO THE PROGRAM?

Yes

SUCCESS RATES

76%

Table of Contents

Physician Recovery Network

Participant Handbook

2019

Southworth Associates, LLC

5530 W Emerald, Boise, ID 83706

(208) 323-9555—phone

(208) 323-9222—fax

www.southworthassociates.net

Table of Contents:

PRN Office Hours

Building availability: 8:00 am—5:00 pm MT, Monday-Thursday, 8:00 am—4 pm MT, Friday

Telephone availability: 7:00 am—5:00 pm MT, Monday-Thursday, 7:00 am—4 pm MT, Friday

Emergency line availability: 24/7 through Emergency Line—(866) 460-9014

2019 Southworth Holidays—Office will be closed.

Tuesday, January 1st

Monday, January 21st

Monday, February 18th

Monday, May 27th

Thursday, July 4th

Monday, September 2nd

Monday, November 11th

Thursday, November 28th

Friday, November 29th

Tuesday, December 24th

Wednesday, December 25th

Drug Testing dates you are not required to check in:

New Year's Day, President's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, Christmas

Participants experiencing an emergency or crisis

should call 911 or visit their local hospital emergency room.

This handbook is intended to provide instruction and direction about the PRN. It is to be used in conjunction with your PRN contract and is simply meant to supplement any information already contained in your contract. It is your responsibility to know and follow the terms of your individualized contract. Your Compliance Monitor will gladly explain your requirements and answer any questions you may have.

Physician Recovery Network Introduction

We are pleased to report that after 32 years of service to the physicians and physician assistants in the State of Idaho, we continue to be a successful advocacy and monitoring program.

One of our main successes has been a quality relationship with the Idaho State Board of Medicine. This is often very helpful when we advocate for our participants. If a physician/physician assistant becomes a participant of the PRN program, but does not have a Stipulation and Order Agreement with the Board of Medicine, PRN categorizes the participant as a self-referral. PRN informally advises the Board of Medicine of the self-referral's involvement with the PRN. The client is advised of, and consents to, this informal exchange of limited information. This potentially helps to protect the client from future disciplinary action by the Board. Historically, the Board of Medicine agrees not to pursue any further investigation relevant to substance use disorders they may already have underway against this client, and furthermore agrees to not take any new action as long as the client is in compliance with the PRN program. The exception to this rule involves cases about which the Board has independently received complaints of such magnitude that it feels compelled to take action. Our experience is that this contributes dramatically to physicians and physician assistants coming in before they are forced by the Board and also leads to improved treatment outcomes. We also meet periodically with the Board of Medicine to exchange information and discuss problems. Confidentiality is protected except as defined by the limited release of information forms signed by all clients in the program, with exception to board referred individuals. If a participant fails to cooperate we are required to report this to the Board of Medicine.

Having reliable funding is absolutely essential for a successful program. Having multiple sources of funding is important in order to promote balance in the program and to add credibility regarding our arms-length status with the Idaho State Board of Medicine. Part of our funding is from medical license fees, via a contract with the Board of Medicine. Another part is from the Idaho Medical Association, donations from medical societies, hospitals, and malpractice insurance companies. Together we are trying to improve the quality of medical care through early identification and treatment and then long-term monitoring of physicians with problems and to reassure the public that we are aggressively pursuing protection of their interests.

The PRN Committee consists of knowledgeable volunteers who are involved because they care about their peers and are willing to become emotionally involved in a cause they consider important. We are also privileged to have the Idaho Medical Association who cares and commits significant resources to make the program work. Finally, we are fortunate to have a full-time staff that is actively creating relationships and setting up appropriate treatment contacts and long term monitoring programs.

Sincerely,

PRN Committee Members

About the Physician Recovery Network

The Physician Recovery Network (PRN) is an abstinence based program that was formed in 1986 with the support of the Idaho Medical Association House of Delegates. The PRN consists of an IMA Committee of 18 volunteer members (15 physicians, 2 physician assistants, and one lay person) from around the state. Half of these members are appointed by the Idaho State Board of Medicine. Willis Parmley, M.D. of Pocatello serves as Chairman of the Committee and Mark Broadhead, M.D. of Reno, NV serves as Medical Consultant. Ben Seymour, CADC, serves as the Program Director.

The PRN was created to help any Idaho physician or physician assistant who is impaired as a result of substance use disorders, mental illness/psychiatric problems, or senility. The program's primary mission is prevention, identification, intervention, and rehabilitation for Idaho physicians and physician assistants who have, or are at risk for, developing disorders which are associated with functional impairment. The PRN provides a network of trained physicians and other healthcare professionals to aid in confidential investigations of alleged physician/physician assistant impairment, and when appropriate, conducts interventions and coordinates placement into a treatment program. The PRN does not provide treatment directly. The PRN then develops and coordinates an individualized long-term monitored recovery program for each participating physician/physician assistant. The PRN seeks to educate Idaho physicians and other involved parties about the nature of the PRN program and the problems of impaired physicians/physician assistants, and establish a liaison with other professional organizations concerned with these issues.

The PRN has become an important source of confidential support to physicians and physician assistants seeking the help they need without necessarily jeopardizing their medical licenses. Most individuals join the program through some form of "benevolent coercion", seeking assistance because of some external pressure, which comes primarily from professional colleagues. However, spouses, hospital administrators, lawyers, and others have also contacted the program to report possible impairment or other abnormal behavior.

For substance use disorders, the PRN cannot force or prescribe recovery. It can and does document behaviors consistent with recovery. The participant has to find their own path to recovery. Participating in recovery activities exposes the participant to others who are seeking recovery too. They share feelings and tools, but just the activities do not guarantee recovery. Vice versa, the tools that work for one person may not work for another.

When physicians/physician assistants follow their recovery program, the PRN can be a powerful advocate. In the past, the PRN has advocated on behalf of physicians/physician assistants to the Board of Medicine, federal agencies, judges, malpractice insurance carriers, and hospitals.

Nationally, professional health programs have high success rates . The PRN's experience is similar of those results. Success is generally defined as a physician/physician assistant achieving a chemically free, professionally productive lifestyle at 5 years after treatment.

The PRN maintains an arms-length relationship with the Idaho State Board of Medicine while at the same time interacting with the Board in a manner that develops trust and satisfies legal requirements. As long as the physician/physician assistant is in compliance with the PRN program requirements, they will not be reported to licensing or disciplinary agencies. The PRN will contact the Board if a physician/physician assistant refuses to comply with PRN recommendations.

The PRN receives financial and staff support from the Board of Medicine. The PRN gratefully acknowledges the Board's support, however, the funds supplied by the Board are restricted in how they can be used and don't cover the entire costs of the PRN. In addition, the PRN receives support from medical malpractice carriers, hospitals, local medical societies, and from individual physician/physician assistants.

PRN Mission Statement

The mission of the Idaho Physician Recovery Network is prevention, identification, intervention, and rehabilitation for Idaho physicians and Physician Assistants who have, or are at risk for developing disorders which are associated with functional impairment. This will be done in a confidential manner consistent with the laws and medical practice acts of the State of Idaho.

Contacting PRN

General Help Line: 208-323-9555 ext. 206

Staff:

Ben Seymour, CADC, Director/Program Director

866-460-9014 | ben@southworthassociates.net

Tiffany East, Senior Compliance Monitor

208-323-9555 ext. 106 | tiffany@southworthassociates.net

Mon-Wed-Fri 7am-4pm MT

Tues-Thurs 8am-5pm MT

Lori Lapp, Quality Assurance/Data Advisor

lori@southworthassociates.net

It's best for you to communicate directly with your designated Compliance Monitor whenever possible.

Monitoring Contract

The PRN is designed to support the recovery process of physicians/physician assistants and to help ensure the safe practice of medicine. **Contract requirements are there to help reinforce your own recovery program!**

This contract serves as a powerful tool toward documenting the recovery process and helping physicians/ physician assistants return to the practice of medicine. The overall substance use disorders monitoring contract is a five year contract and is designed to guide and document the participant's recovery from substance use disorders. Requirements of this contract include, but are not limited to, weekly attendance at mutual support group meetings (i.e. 12-Step meetings), weekly attendance at a professionally facilitated support group meeting, regular meetings with a 12-step sponsor , and participation in random toxicology drug screening.

For the physicians/physician assistants who need monitoring for psychiatric/mental health issues, a contract is designed similar to the substance use disorders contract but also includes regular meetings with a psychiatrist or therapist who monitors and reports on the behavioral and mental health aspect of recovery.

Once a PRN contract is signed each participant is responsible for all requirements. PRN Compliance Monitors are considering the following compliance issues when advocating for participants:

- Consistent check-in to FS Solutions to see if a drug screen is required that day
- Providing toxicology samples that are negative & valid (i.e. not dilute)
- Timely completion/submission of reports
- Attendance/participation at required meetings

Participants are expected to meet with the Committee in person at least once while under contract. Typically we try to schedule these meetings within the first year of contract.

Drug Testing

Participants must check in to FS Solutions (call-in, check on-line, or check mobile app) every Monday-Friday between 5am-5pm Mountain time.

Check-in is not required on these holidays:

- New Year's Day
- Memorial Day
- 4th of July
- Labor Day
- Thanksgiving Day
- Christmas Day

Generally, drug testing begins at a frequency averaging once per week. Other forms of drug testing may be added into the random cycle at any time. Examples include, but are not limited to, hair and/or blood tests.

PRN does not accept any other drug testing other than results completed by using FS Solutions' Chain of Custody (i.e. Drug Court tests, other 3rd party tests, etc.)

When a participant misses a required check-in to FS Solutions they can choose to either self-test with one of their FS Solutions provided Chain of Custody forms or not test and risk having been selected. If they elect to test they should use a test option number provided to them by their Compliance Monitor.

If a participant has a shy bladder or is otherwise not able to produce enough sample they have few options. They can either stay at the testing facility until they are able to produce enough for a split specimen; they can authorize the testing facility to accept a non-split specimen so long as they understand that if the specimen comes back questionable they have no way of re-testing it if they disagree with the results; or they can return to a testing facility later that day with a new Chain of Custody form and try again.

You are responsible for assuring you have Chain of Custody forms on hand at all times. If you need to reorder forms you'll need to do so directly through FS Solutions. You can either:

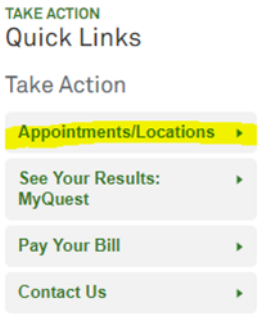
1) login to the Testing Notification System (www.fssolutions.com) and select Forms/Reports, Chain of Custody Order Form, or

2) contact FS Solutions by phone at (833) 476-1173.

Drug Testing continued

You can locate testing sites nationwide by using the following website: http://www.questdiagnostics.com/home.html

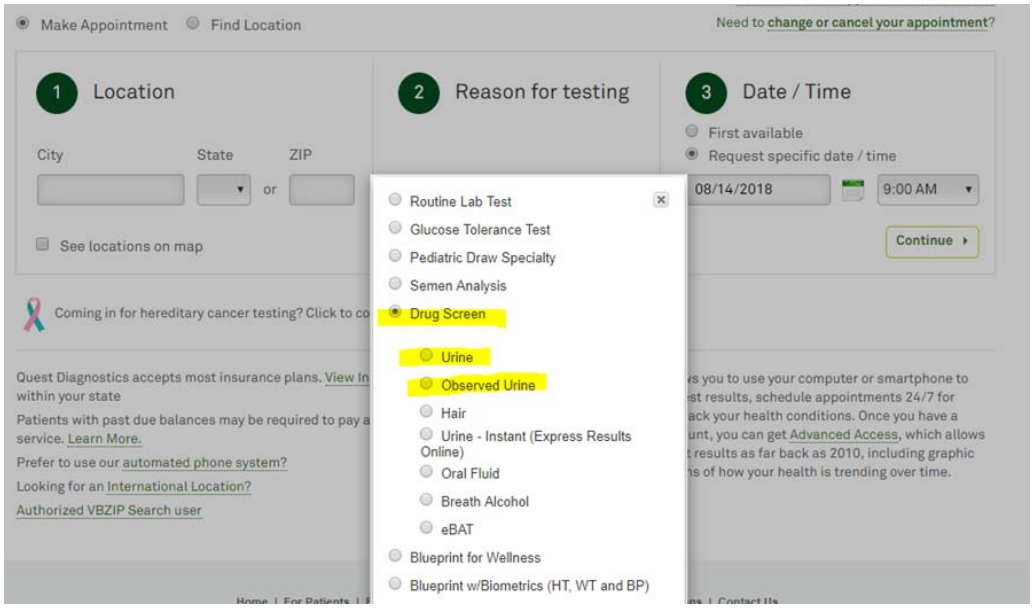
1. Click on the "Appointments/Locations" on the lower left



2. Fill out the information requested on the new screen:

   *City and state or zip code

   *Reason for testing would be 'drug screen' and you will need to choose urine or observed urine if you need observed collections. **If you question if your testing needs to be observed or not reach out directly to your Southworth Associates case manager for guidance**



   *Date and time (if applicable, this is not required, you can leave it on first available)

3. Hit continue, sites available will populate below this section. You can then click on the individual sites for further information such as hours and phone numbers.
4. Both Quest sites and Quest preferred sites show here and you may use any of these facilities.
5. Appointments are not necessary but do take priority over walk-ins. Please be sure to bring your valid government ID and Chain of Custody form.

Call FS Solutions with any questions or concerns at 833.476.1173

Travel/Vacation Requests

You should notify PRN in writing at least one (1) week prior to departure anytime you travel out of town during the Monday-Friday work week. If there are testing sites near where you will be traveling to, you will be expected to continue to check in and test if selected. If you are traveling to an area where no sites are within a reasonable distance, as determined by PRN, and/or if you have plans that will make testing impossible you can make a request to be excused during this time. This request should outline the following: 1) where you are going, 2) why you are going, 3) how long you plan on being away, and 4) what requirements exactly you cannot fulfill while traveling.

Based on the above information and your case history it is up to your Compliance Monitor to determine whether or not you will be excused from contract requirements if you travel out of town. If approved, PRN will only excuse participants from the specific item(s) requested. If you did not request to be excused from a particular requirement you will be expected to continue to fulfill it as outlined in your contract.

If you forget your Chain of Custody forms when traveling it may be possible to set up an electronic Chain of Custody form with a local lab. You'll need to contact your Compliance Monitor as early in the day as possible if this is necessary as it may take some time to accomplish.

Meeting Attendance

Client Attendance Report (CAR) forms as well as instructions on how to fill out these forms can be downloaded via our website: http://www.southworthassociates.net/monitoring/physician-recovery-network

CAR forms must be turned in by the 5th of the month. Totals for monthly meeting attendance will be tallied on the 10th of each month and low meeting letters sent at that time if applicable.

While in your ninety (90) meetings in ninety (90) days phase of your contract only outpatient treatment classes and 12-Step meetings count toward this goal. Health Professionals support group, sponsor meetings, etc. are not counted toward your 90/90 nor are they counted toward your 12-Step meeting requirement once 90/90 is completed. Outpatient treatment classes are only counted towards your meeting attendance during the 90/90 requirement.

If a participant misses a Health Professionals support group they must first notify their designated Compliance Monitor as well as their support group facilitator with an explanation on why they are missing the required group. Secondly, if you are excused from group by your Compliance Monitor you will be asked to attend two extra 12-Step meetings as replacement. Please be mindful to mark those replacement meetings on your CAR forms so your attendance is tallied correctly for the month. *An exception to this is if you attend the Turnboom/Neeser group in Boise at a rate less than weekly. If so, your missed support group meeting must be made up with another Turnboom/Neeser support group meeting within six weeks of the missed group.

A participant cannot request a decrease in Health Professionals support group attendance rate until they have met at least 90 times with the group.

PRN does not accept on-line meetings.

Caduceus meetings will count toward your 12-Step meeting requirements and should be noted the same way as 12-Step meetings on your CAR.

Worksite Monitors

A Worksite Monitor is someone who has met the PRN's guidelines and is viewed as encouraging and supportive of the participant's recovery and who understands the importance of their confidentiality. They are willing to observe the participant in their employment setting, regularly update the PRN, as well as immediately notify the PRN if they notice any behavioral or emotional changes that cause concern.

You are responsible for nominating your Worksite Monitor. Your designated Compliance Monitor will then contact your nominee and determine if they are eligible to act in this capacity.

Generally, Worksite monitors must:

- Be someone in the client's workplace
- Not be a subordinate or employee of the person being monitored
- Not currently a participant in the PRN program
- Have prior approval by PRN for any conflicts of interest

PRN will call your Worksite Monitor in between quarters for a verbal update as well as send quarterly requests for written updates.

Overall Peer Monitors

An Overall Peer Monitor is a peer (typically another recovering Health Professional) that meets with participants at least once a month to:

1) Assess the recovery process (including how he/she is doing in recovery and how he/she is feeling about his/her recovery)

2) Assess compliance with the PRN contract

3) Support the physician's progressive efforts in recovery

4) Assess how the physician is managing work-related stressors

5) Discuss work-related issues that have/may have an impact on recovery

The assigning of Overall Peer Monitors will be used on a case by case basis as defined and articulated by the PRN Committee and could include any or all of the following:

1) Participants who are on multiple contracts,

2) Participants having non-compliance issues,

3) Participants with behavioral needs as defined by the PRN Committee,

4) Participants with more than expected difficulty with abstinence in the opinion of the PRN Committee.

PRN will review the Overall Peer Monitor/participant assignment at least annually.

Timeline for Requests

The PRN Committee reviews written requests on a quarterly basis (January, April, July, and October). When making a request the participant is expected to look internally and be mindful of their recovery program. Please ask your Compliance Monitor for a list of questions you will be expected to answer in order to facilitate this internal conscientiousness.

Only one request at a time can be approved by the Committee. For each request change period, the participant may request a decrease of no more than:

- Six toxicology tests/year
- One mutual support group (12-Step)/week—*will never drop lower than 1 meeting/week*
- One sponsor meeting/month—*will never drop lower than 1 meeting/month*
- One Health Professionals support group meeting/month—*will never drop lower than 1 meeting/month and must have met at least 90 times with the group*

No changes in requirements will be made in the first year of your contract. After your first year you can make a request on the following schedule:

- After 1 year
- 1.5 years
- 2 years
- 2.5 years
- 3 years
- 3.5 years
- 4 years
- 4.25 years
- 4.5 years
- 4.75 years

WHEN DOES THE PRN COMMITTEE MEET?

As you know PRN client requests must be reviewed at the quarterly PRN Committee meeting. Although we don't have all the meeting dates for the year, the meetings tend to be scheduled in January, April, July and October with the agenda usually being closed two weeks prior to the meeting. A good rule of thumb is to have your request SENT to the PRN office no later the beginning of the month prior to the PRN meeting. So send in your requests by the beginning of December for the January meeting, beginning of March for the April meeting, beginning of June for the July meeting, and beginning of September for the October meeting.

PRN Request Form Instructions

INFO: The PRN Committee reviews requests on a quarterly basis. Only one request at a time can be approved by the Committee. The PRN Committee generally meets in January (phone), April, July (phone) and October. If you want to have your request added to the agenda in time please have this form filled out the beginning of the month prior to the meeting. i.e. early December (for Jan), early March (for April), early June (for July) and early Sept (for Oct). For each request change period, the participant may request a decrease of no more than:

Six toxicology tests/year— will never drop lower than 18 tests/year
One mutual support group (12-Step)/week—will never drop lower than 1 meeting/week
One sponsor meeting/month—will never drop lower than 1 meeting/month
One Health Professionals support group meeting/month—will never drop lower than 1 meeting/month and must have met at least 90 meetings with the group

This request form most likely will not be used for special requests, i.e. return to work, support for reinstatement of DEA.

REQUEST SCHEDULE: after 1 year, 1.5 years, 2 years, 2.5 years, 3 years, 3.5 years, 4 years, 4.25 years, 4.5 years and 4.75 years.

INSTRUCTIONS

Please answer and submit questions A – M to the PRN office. The PRN Committee reviews requests on a quarterly basis. **Feel free to save this document to your computer and type in the responses.**

A. Please list the meetings you attend each week. Please include the name, type of meeting and format. Please identify your home group. Discuss why you go to this meeting and its strengths and weaknesses.

B. Please list your sponsor. Tell us the nature of your current relationship; how often you meet, what do you discuss in terms of your recovery program. What are the strengths and weaknesses of your current relationship with your sponsor?

C. Who are your current monitors? Please list them by name. Describe the nature of your relationship, how often you meet and strengths and weaknesses of your current relationship with your monitors.

D. Describe your current spiritual program.

E. Please describe how you deal with strong emotions and how you achieve balance in your life. Please be specific. Give examples from the last 6 months.

F. Please list any compulsive substitute behaviors you had engaged in since entering recovery. How do you deal with these compulsions?

G. Please list your current significant relationships. What are the strengths and weakness of each of these relationships?

H. Please describe your current physical health. What do you do to maintain it? Please describe any exercise programs and leisure time activities you routinely engage in.

I. Please describe your current professional status. Describe your work and job duties. How would you describe your current workplace attitude? Please describe the strengths and weaknesses of your current work life.

J. Please describe your current financial status. Do you plan to make any changes in the foreseeable future? If so, what is your plan?

K. What are you currently doing regarding continuing medical education? What is the status of your board certification?

L. Looking over your entire program of recovery, what would you say is your weakest area? What is your strongest area?

M. Please list your request for requirement changes. Please explain why you wish this change to be implemented. How do you feel it will benefit your program?

Relapse

A relapse will result in an automatic review with the PRN Committee to determine the next course of action. Typical results of this review include a re-evaluation and following of the new evaluation recommendations.

Your Compliance Monitor will ask you to submit a Letter of Explanation regarding the relapse in order to get your perspective on what happened and/or what led up to the relapse.

If the PRN Committee decides not to officially report the relapse to the Board of Medicine, PRN will still notify the Board of Medicine informally of the relapse and the course of action we have taken.

Medications

If a participant is prescribed a controlled substance and/or a potentially addictive medication, PRN will recommend that the participant not practice until evidence is provided of discontinuation of that medication (i.e. negative drug screen or statement from prescriber noting the discontinuance date).

If a participant cannot get off a prescribed controlled substance or potentially addictive medication they will have their case go before the PRN Committee to get advocacy to work.

PRN utilizes "The Medication Guide for a Safe Recovery" issued by Talbott Recovery Center as a guideline on whether a medication is safe or risky for a person in recovery to take. A copy of this Guide can be found here: http://www.southworthassociates.net/monitoring/physician-recovery-network. Click on Safe Medication List.

- Class A drugs should be absolutely avoided
- Class B drugs should only be taken with physicians knowledge of the participants' recovery
- Class C drugs should be safe to take

Participants must notify PRN of any over-the-counter medications they take along with duration of use.

A Yearly Updated Prescription form as well as list of medications containing alcohol/Guide to Alcohol Free Products can be downloaded from our website: http://www.southworthassociates.net/monitoring/physician-recovery-network

Agonist Therapy Policy

It is the clinical opinion of the PRN that when it comes to the treatment of Substance Use Disorder, abstinence from potentially addicting substances is the pharmacologic gold standard. As such, abstinence is the expected state of all professionals who are attempting to return to work in the health care fields. The use of harm reduction techniques such as agonist therapy should be reserved for the severest forms of Substance Use Disorders and are, in general, considered too high risk to be allowed to return to work in patient care.

Still, exceptions may be made on a case-by-case basis under highly modified monitoring contracts. Agonist therapy may be considered appropriate for individuals who have been using the drug either IV or who have met the criteria for severe use disorder for a period of years. They must have had at least two relapses after appropriate treatment or while under monitoring. For those with Opiate Use Disorder, at least one of those relapses needs to have occurred while on naltrexone or other opiate receptor-blocking agent. Having proven they have the severest form of the disease, candidates for agonist therapy will be monitored for as long as they are on this form of therapy. Reduction in monitoring or recovery requirements will not be considered as long as the patient is on this form of therapy. Modifications to the contract shall be at the monitoring agencies discretion and for increased efficiency of efficacy of monitoring only. Should the individual discontinue agonist therapy, the individual may then sign a new standard contract. Time spent on agonist therapy shall not count toward the completing of a standard contract.

Ketamine Policy

Given the currently popular but off label use of the dissociative anesthetic ketamine for the treatment of depression, the PRN set the following guidelines for the drug's use in PRN participants:

1. PRN participants must notify the PRN of their intention to engage in ketamine treatment prior to initiating such treatment.
2. Participants cannot work while undergoing ketamine treatment and possibly for an extended period of time afterwards depending upon the manner in which the ketamine is used.
3. Participants agree to independent evaluation by a physician of facility of the PRN's choice in order to independently verify the need for such treatment and the current level of impairment of the participant.
4. Participant agrees to release all medical and /or psychiatric records to the PRN for review prior to initiating ketamine treatment.

Treating others in the PRN

If a participant wants to treat another participant in the program, prior to treatment you are expected to inform your designated Compliance Monitor of the situation and they will review this with the Medical Consultant and/or Program Director. The Medical Consultant/Program Director can either:

- Approve of this relationship with enough documentation from both parties or
- Will recommend the participant find another provider for that particular situation.

Working with others in the PRN

PRN discourages monitored participants from practicing together as members, employers, employees, partners, supervisors or supervisees within the same medical practice entity. For the purpose of this provision, the term “medical practice entity” shall not mean a hospital.

If you find yourself working or potentially working with another PRN participant, you are asked to contact your designated Compliance Monitor with the specifics and they will review your case with the PRN Committee to obtain approval for this venture.

If you are concerned whether or not this policy applies to you please contact your designated Compliance Monitor.

Termination/Graduation-

Self-referred participants must request graduation in writing and the Committee will review the case. The PRN Committee only meets quarterly to review these requests and thus, depending on scheduling, you may be required to be monitored past your PRN contract date.

A suggested timeline for a Self-referred participant to request graduation would be:

- At least three months prior to your PRN contract end date send a letter to the PRN Committee requesting graduation. Your Compliance Monitor can help you figure out at which PRN Committee meeting your request needs to be reviewed.

Board-referred participants must request PRN's support for termination of their Stipulation & Order (S&O) in writing as well as send a request to the Board of Medicine directly to terminate their S&O. If the Committee agrees to support the termination of the S&O then PRN will send a support letter to the Board of Medicine. The Board of Medicine, as well as the PRN Committee, only meets quarterly to review these requests and thus, depending on scheduling, you may be required to be monitored past your PRN contract date.

A suggested timeline for a Board referred participant to request graduation would be:

- At least three months prior to your PRN contract end date send a letter to PRN Committee requesting their support for termination of your S&O. Your Compliance Monitor can help you figure out at which PRN Committee meeting your request needs to be reviewed.

- At least three months prior to your PRN contract end date send a letter to the Board of Medicine requesting to get on their upcoming agenda for termination of your S&O.

Only the Board of Medicine can release Board-referred participants. PRN must wait for notification from the Board that the participant either: 1) graduated and thus their S&O has been terminated or 2) was dismissed and thus canceled/revoked/surrendered their license, before releasing them from their contract.

- Monitoring fees continue to accrue until either one of the above items is met.

We encourage you to make the most of our website as is contains many helpful links, documents, and other information:

http://www.southworthassociates.net/monitoring/physician-recovery-network

Please review your contract regularly and contact your Compliance Monitor directly should you have any questions regarding this Handbook or any requirements!

The Final Report

After the individual leaves, each clinician at the CDE site will validates their respective report. These reports may include:

- History & Physical
- Psychosocial
- Psychiatric Assessment
- Psychological Evaluation
- and the definitive report
- The Integrated Discharge Summary
- Circling the Diagnostic Wagons
- The Integrated Discharge Summary
- Patient Identification
- Substance Use and Treatment History
- Evaluation Team Members
- Psychological Testing Summary
- Psychiatric Assessment
- Medical History (including Laboratory Studies)
- Drug Screens
- Significant Findings – Summary
- Final DSM-5 Diagnosis
- Recommendations (including fitness for-duty)

If treatment is recommended, you are not required to attend treatment at the same site you received an evaluation. You also have the right to a second opinion. In either of these cases please contact the Southworth Associates staff for a list of approved evaluation/treatment center options.

Southworth Associates

5530 W. Emerald St.
Boise, ID 83706

Phone: (800) 386-1695
(208) 323-9555

www.southworthassociates.net

Clinical Diagnostic Evaluations*

SOUTHWORTH
ASSOCIATES INTERNATIONAL

Lending a hand….any time, any place

*Courtesy of John Pustaver, CDE Director, Seasons In Malibu - in memory of Garrett O'Connor, MD

What Does a Clinical Diagnostic Evaluation (CDE) Accomplish?

The Purpose of a Clinical Diagnostic

Evaluation is to:

1. Determine whether or not the individual meets DSM-V criteria warranting a diagnosis of a substance use disorder or another psychiatric condition.
2. Determine whether or not the individual requires treatment, and if so, what type.
3. Determine whether or not the individual is currently fit for duty or safe to return to practice (i.e. medicine, pharmacy, dentistry, or nursing).

If someone meets DSM criteria for a substance use disorder the evaluator will make recommendations about the type of treatment (residential, dual diagnosis, length of stay). There is NO expectation that the patient is required to complete treatment at the same location as the evaluation. You have choices! We have a list of preferred providers to choose from.

The CDE Program was NOT designed to:

- Convince individuals diagnosed with a substance use disorder that they are "alcoholics" or "addicts"
- Take the place of an intervention
- Fill beds
- Help referents (e.g., a physician health program, medical board, airline) get their clients into treatment

The Team and the Evaluation Process

When receiving a Clinical Diagnostic Evaluation

The Team Consists of:

- An addiction medicine physician.
- An addiction psychiatrist.
- A neuropsychologist.
- And a program coordinator/director.

A CDE is a team effort – every member of the Team does their individual part, but the final diagnosis is only made AFTER we have received and reviewed ALL the available information.

The process: will consist of:

- Pre-admission assessment.
- Demographic information.
- Who is asking for the evaluation and why.
- Request collateral information in advance whenever possible.
- Assure the individual that we NEVER make assumptions about any diagnosis until the evaluation is complete.
- Nursing assessment.
- History and physical and lab work.
- Drug screening (UDS with EtG/EtS, hair sample test and PEth).
- Psychological testing (MMPI-2-RF, MCMI-III, MicroCog and, if needed, WAIS-IV).
- Psychiatric assessment.
- Psychological evaluation.
- Psychosocial.
- Request for a family member or friend to accompany the individual to the evaluation.
- Telephone interviews.
- Exit Interview – usually on the morning of the 3rd day.
- And then further collection and review of collateral information not available to us during the time (usually 3 days) the individual was with us.

Collateral Information

Collateral information

The importance of receiving and reviewing any and all pertinent collateral information cannot be overstated.. The evaluator will receive collateral information from:

- Psychiatric/psychological reports.
- Treatment records.
- Letters of support.
- Information related to licensure from the licensing agency's website.
- Presence of a family member.
- Collateral telephone interviews with peers, employer, close friends.
- Polygraph test results.
- And sometimes sponsors (although they try to avoid involving members of 12-Step groups).

Fitness-for-duty collateral information

- If the evaluation is for a licensed professional, a refusal to allow us access to pertinent collateral information terminates the evaluation.

- Two principles regarding collateral information:

1. the evaluator cannot be blocked from receiving pertinent information.
2. (he evaluator tries to avoid unnecessarily disrupting the individual's personal life or their professional life.

After the patient leave the evaluation, the evaluation team validates their respective reports.

Client Activity Report (CAR) Forms – Instructions

- Please put your first and last name on the form. If your name is not legible or is not included on the form, it will not be credited toward your contractual requirements.

- **This form is due the 5th of the following month**. Please send them in at minimum once a month. You can **mail in (5530 W. Emerald Boise, Idaho 83706), fax (208-323-9222), and/or email** your monthly attendance form to the PRN office. Please be aware that a low meeting non-compliance letter will go out around the 10th of each month so it is important you get these attendance forms in on time.

- Each month you will supply the PRN office with a log of meetings attended. Those meetings will include:
  - Mutual Support Groups (i.e. AA, NA or other 12 step)
  - Sponsor meetings
  - Group meetings (i.e. IOP, relapse prevention, aftercare or other treatment or group meetings)
  - Other meetings (counselor meetings, individual sessions)

- Please clearly define the type of meeting attended so you can get proper credit. If you went to an AA meeting, mark AA. If you attended a treatment meeting and an AA meeting on the same day, please use two different lines to differentiate between the meetings.

- Attendance at facilitated support groups do not need to be marked on these form unless a special exception has been made. PRN will gather your support group attendance from the sign in sheets provided by the support group facilitators.

- Insure that those persons designated to verify that activities are completed sign the reporting form in the appropriate place. If there is not a facilitator for the group you are attending, have an AA group member or your sponsor sign the form verifying your participation. If applicable, he/she may include other comments.

- NEED A FORM? Forms can be obtained from **www.southworthassociates.net** or email your compliance monitor with a request and he/she will email you a new form.

- Questions: Please call the PRN office at (208) 323-9555.

Client Activity Report

Month of: _____

Client Name (Please Print) _____

	Date	AA/NA	Sponsor	Group	Other	Comments	Signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

Client Signature _____

5530 W. Emerald St.
Boise, Idaho 83706 Fax 208-323-9222 www.southworthassociates.net

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

To the extent possible under federal and state law, I consider all my medical records, including records concerning my activity with the Physician Recovery Network, to be privileged and confidential. I, therefore, give my permission for the Idaho Medical Association PRN Committee representatives to give reports to and receive reports from the person(s) or agency(ies) named below. I understand these reports will contain information regarding my involvement with PRN and will include information regarding any chemical dependence and/or mental illness problems I may have and information regarding my progress in recovery. Any limitations regarding the content of information in these reports are as defined below. I further acknowledge that the purposes of these reports were explained to me and that this consent is given of my own free will.

1. Physician Monitor: _____

   Report Limitations: _____

2. Hospitals where I have privileges:

   1. _____ 2. _____ 3._____

   Report Limitations: _____

3. Representative of hospital administration:_____

   Report Limitations:_____

4. Physician associate: _____

   Report Limitations:_____

5. Spouse or significant other:_____

   Report Limitations: _____

6. Office manager and/or nurse:_____

   Report Limitations:_____

7. Personal physician and Dentist:_____

   Report Limitations: _____

8. Idaho State Board of Medicine: **Executive Director or designees**

   Report Limitations: a. Informal, verbal notification of program participation.

   b. If I become out of compliance with this contract, NO LIMITATIONS.

9. PRN Physician Support Group Staff (including Turnboom Counseling Center or WPHP):_____

   Report Limitations: _____

10. FirstSource Solutions: For the purposes of UA collection and testing

11. Others: a. _____

    b._____

    c. _____

If not previously revoked, this consent will terminate five years from _____.

SIGNED: _____ Date:_____

WITNESS:_____ Date:_____

PRN
Physician Recovery Network
5530 W. Emerald St.
Boise, ID 83706
Office: (208) 323-9555
Fax: (208) 323-9222

YEARLY UPDATED PRESCRIPTION DRUG LIST

This form is to be filled out by any practitioner who is prescribing you medications.
The Completed form must be mailed/faxed by the practitioner's office.

_____
(Printed Participant's Name)

Prescription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I have been informed that this patient is involved in a monitoring program. I understand that his/her drug(s) of choice is: _____

I have been informed that this patient is involved in a monitoring program. I understand that he/she has a diagnosis of: _____

_____ _____
Practitioner's Name (Please print) Practitioner's Signature

_____ _____
Practitioner's Phone Number Date

_____
Practitioner's Address

PRN Request Form Instructions

INFO: The PRN Committee reviews requests on a quarterly basis. Only one request at a time can be approved by the Committee. The PRN Committee generally meets in January (phone), April, July (phone) and October. If you want to have your request added to the agenda in time please have this form filled out the beginning of the month prior to the meeting. i.e. early December (for Jan), early March (for April), early June (for July) and early Sept (for Oct).

For each request change period, the participant may request a decrease of no more than:

Six toxicology tests/year— will never drop lower than 18 tests/year
One mutual support group (12-Step)/week—will never drop lower than 1 meeting/week
One sponsor meeting/month—will never drop lower than 1 meeting/month
One Health Professionals support group meeting/month—will never drop lower than 1 meeting/month and must have met at least 90 meetings with the group

This request form most likely will not be used for special requests i.e. return to work, support for reinstatement of DEA.

REQUEST SCHEDULE: after 1 year, 1.5 years, 2 years, 2.5 years, 3 years, 3.5 years, 4 years, 4.25 years, 4.5 years and 4.75 years.

INSTRUCTIONS

Please answer and submit to the PRN office questions A – M. The PRN Committee reviews requests on a quarterly basis. **Feel free to save this document to your computer and type in the responses.**

A. Please list the meetings you attend each week. Please include the name, type of meeting and format. Please identify your home group. Discussed why you go to this meeting and its strengths and weaknesses.

B. Please list your sponsor. Tell us the nature of your current relationship; how often you meet, what do you discuss in terms of your recovery program. What are the strengths and weaknesses of your current relationship with your sponsor?

C. Who are your current monitors? Please list them by name. Describe the nature of your relationship, how often you meet and strengths and weaknesses of your current relationship with her monitors.

D. Described your current spiritual program.

E. Please describe how you deal with strong emotions and how you achieve balance in your

life. Please be specific. Give examples from the last 6 months.

F. Please list any compulsive substitute behaviors you had engaged in since entering recovery. How do you deal with these compulsions?

G. Please list your current significant relationships. What are the strengths and weakness of each of these relationships?

H. Please describe your current physical health. What do you do to maintain it? Please describe any exercise programs and leisure time activities you routinely engage in.

I. Please describe your current professional status. Describe your work and job duties. How would you describe your current workplace attitude? Please describe the strengths and weaknesses of your current work life.

J. Please describe your current financial status. Do you plan to make any changes in the foreseeable future? If so, what is your plan?

K. What are you currently doing regarding continuing medical education? What is the status of your board certification?

L. Looking over your entire program of recovery, what would you say is your weakest area? What is your strongest area?

M. Please list your request for requirement changes. Please explain why you wish this change to be implemented. How do you feel it will benefit your program?

Guide to Alcohol-Free Products
&
Incidental Exposure Index
&
Products Containing Alcohol

HOW TO USE THIS GUIDE

FirstSource Solutions wishes to thank the Talbott Recovery Campus for granting FirstSource their permission to reprint and distribute this important guide.

This document was developed through a collaborative effort between some of the best minds in addiction care today, to help you make wise decisions concerning over-the-counter (OTC) or prescription medications and help you to avoid incidental exposure to alcohol which could threaten your hard won recovery.

Please remember that this guide is only intended as a quick reference and never as a substitute for the advice of your own personal physician. It is essential that you inform all of your personal physicians, dentists and other health care providers of your chemical dependency history so that medications can be prescribed safely and appropriately when they are deemed necessary. Never discontinue or make any changes in the doses of medication that you may have been prescribed. Doing so may result in unexpected problems such as withdrawal reactions, which in some cases can be life-threatening. The bottom line is that a recovering addict or alcoholic needs to become a good consumer. Remember that "Recovery Is Its Own Reward." Being healthy and regaining a happy life is your responsibility!

Alcohol-Free Products

The following is a selection of alcohol-free products grouped by therapeutic category. The list is not comprehensive. Manufacturers change product ingredients and brand names frequently. Always check product labeling for definitive information on specific ingredients. Manufacturers are listed after each product name. Please note that some of these medications, while alcohol-free, do contain compounds with addiction liability and are thus Class B medications. Such products are preceded by an asterisk (*).

Analgesics:

Acetaminophen Infants Drops	**Ivax**
Actamin Maximum Strength Liquid (acetaminophen)	**Cypress**
Addaprin Tablet (ibuprofen)	**Dover**
Advil Children's Suspension (ibuprofen)	**Wyeth Consumer**
Aminofen Tablet (acetaminophen)	**Dover**
Aminofen Max Tablet (acetaminophen)	**Dover**
APAP Elixir (acetaminophen)	**Bio-Pharm**
Aspirtab Tablet (aspirin)	**Dover**
Genapap Children Elixir (acetaminophen)	**Ivax**
Genapap Infant's Drops (acetaminophen)	**Ivax**
Motrin Children's Suspension (ibuprofen)	**McNeil Consumer**
Motrin Infants' Suspension (ibuprofen)	**McNeil Consumer**
Silapap Children's Elixir (acetaminophen)	**Silarx**
Silapap Infant's Drops (acetaminophen)	**Silarx**
Tylenol Children's Suspension (acetaminophen)	**McNeil Consumer**
Tylenol Extra Strength Solution (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Drops (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Suspension (acetaminophen)	**McNeil Consumer**

Anti-Asthmatic Agents:

Dilor-G Liquid (guaifenesin/dyphylline)	**Savage**
Elixophyllin-GG liquid (guaifenesin/theophylline)	**Forest**

Anti-Convulsants:

Zarontin Syrup (Ethosuximide)	**Pfizer**

Antiviral Agents:

Epivir Oral Solution (Lamivudine)	**GlaxoSmithKline**

Cough/Cold/Allergy Preparations:

***Accuhist Pediatric Drops** (brompheniramine/pseudoephedrine)	**Propst**
***Alka Seltzer Plus Day Cold** (acetaminophen, dextromethorphan, phenylephrine)	**Bayer**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

*Alka Seltzer Plus Night Cold (acetaminophen, dextromethorphan, phenylephrine, chlorpheniramine, doxylamine)	Bayer
*Allergy Relief Medicine Children's Elixir (diphenhydramine)	Hi-Tech Pharmacal
*Andehist DM Drops (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM Syrup (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM NR Liquid (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist DM NR Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist NR Syrup (carbinoxamine/pseudoephedrine)	Cypress
*Bayer Alka Seltzer Plus Cold & Cough (acetaminophen, dextromethrophan, phenylephrine, chlorpheniramine)	Bayer
*Benadryl Allergy Solution (diphenhydramine)	Pfizer Consumer
*Biodec DM Drops (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Biodec DM Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Broncotron Liquid (pseudoephedrine)	Seyer Pharmatec
*Buckleys Mixture, (dextromethorphan)	Novartis
Carbatuss Liquid (phenylephrine/guaifenesin)	GM
Cepacol Sore Throat Liquid (benzocaine)	J.B. Williams
*Children's Benadryl Allergy, (diphenhydramine)	Pfizer
*Chlor-Trimeton Allergy Syrup (chlorpheniramine)	Schering Plough
*Codal-DM Syrup (dextromethorphan/phenylephrine/pyrilamine)	Cypress
*Creomulsion Complete Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Creomulsion Cough Syrup (dextromethorphan)	Summit Industries
*Creomulsion For Children Syrup (dextromethorphan)	Summit Industries
*Creomulsion Pediatric Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Delsym Cough Suppressant (dextromethorphan)	Cell Tech
*Despec Liquid (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin/ phenylephrine)	International Ethical
*Diabetic Tussin Allergy Relief Liquid (chlorpheniramine)	Healthcare Products
*Diabetic Tussin DM Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Capsule (guaifenesin/dextromethorphan)	Healthcare Products
Diabetic Tussin EX Liquid (guaifenesin)	Healthcare Products
*Diabetic Tussin Nighttime Formula Cold/Flu Relief (dextromethrophan, acetaminophen, diphenhydramine)	Healthcare Products
*Dimetapp Cold & Fever Children's Suspension (ibuprofen/pseudoephedrine)	Wyeth Consumer
*Double-Tussin DM Liquid (guaifenesin/dextromethorphan)	Reese
*Dynatuss Syrup (carbinoxamine/pseudoephedrine/dextromethorphan)	Breckenridge
*Dynatuss EX Syrup (guaifenesin/dextromethorphan/pseudoephedrine)	Breckenridge
*Entex Syrup (phenylephrine/guaifenesin)	Andrx

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Father John's Medicine Plus Drops** (chlorpheniramine/ phenylephrine/ dextromethorphan/ guaifenesin/ammonium chloride)	**Oakhurst**
***Friallergia DM Liquid** (brompheniramine/pseudoephedrine/dextromethorphan)	**R.I.D.**
***Friallergia Liquid** (brompheniramine/pseudoephedrine)	**R.I.D.**
***Gani-Tuss-DM NR Liquid** (guaifenesin/dextromethorphan)	**Cypress**
***Genahist Elixir** (diphenhydramine)	**Ivax**
***Giltuss Pediatric Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Giltuss Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Guaicon DMS Liquid** (guaifenesin/dextromethorphan)	**Textilease Medique**
***Guai-Dex Liquid** (guaifenesin/dextromethorphan)	**Alphagen**
***Guaifed Syrup** (phenylephrine/pseudoephedrine/guaifenesin)	**Muro**
***Hayfebrol Liquid** (chlorpheniramine/pseudoephedrine)	**Scot-Tussin**
***Histex Liquid** (chlorpheniramine/pseudoephedrine)	**TEAMM**
Histex PD Drops (carbinoxamine)	**TEAMM**
Histex PD Liquid (carbinoxamine)	**TEAMM**
***Hydramine Elixir**(diphenhydramine)	**Ivax**
***Hydro-Tussin DM Elixir** (guaifenesin/dextromethorphan)	
***Kita La Tos Liquid** (guaifenesin/dextromethorphan)	**R.I.D.**
***Lodrane Liquid** (brompheniramine/pseudoephedrine)	**ECR**
***Medi-Brom Elixir** (brompheniramine/pseudoephedrine/dextromethorphan)	**Medicine Shoppe**
***Motrin Cold Children's Suspension** (ibuprofen/pseudoephedrine)	**McNeil Consumer**
***Nalex-A Liquid** (chlorpheniramine/phenylephrine)	**Blansett Pharmacal**
***Nalspan Senior DX Liquid** (guaifenesin/dextromethorphan)	**Morton Grove**
***Neotuss-D Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**A.G. Marin**
***Norel DM Liquid** (chlorpheniramine/phenylephrine/ dextromethorphan)	**U.S. Pharmaceutical**
Orgadin Liquid (guaifenesin)	**American Generics**
Organidin NR Liquid (guaifenesin)	**Wallace**
***Palgic-DS Syrup** (carbinoxamine/pseudoephedrine)	**Pamlab**
***Panmist DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	**Pamlab**
***Panmist-S Syrup** (guaifenesin/pseudoephedrine)	**Pamlab**
***PediaCare Cold + Allergy Children's Liquid** (chlorpheniramine/pseudoephedrine)	**Pharmacia**
***PediaCare Cough + Cold Children's Liquid** (chlorpheniramine/ pseudoephedrine/ dextromethorphan)	**Pharmacia**
***PediaCare Nightrest Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Pharmacia**
***Pediahist DM Syrup** (brompheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**Boca**
***Pedia-Relief Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Major**
Pediatex Liquid (carbinoxamine)	**Zyber**
***Pediatex-D Liquid** (carbinoxamine/pseudoephedrine)	**Zyber**
Phanasin Syrup (guaifenesin)	**Pharmakon**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

Phanatuss Syrup (guaifenesin)	**Pharmakon**
***Phena-S Liquid** (chlorpheniramine/phenylephrine)	**GM**
***Poly-Tussin DM Syrup** (chlorpheniramine/phenylephrine/dextromethorphan)	**Poly**
***Primsol Solution**(trimethoprim)	**Medicis**
***Prolex DM Liquid** (guaifenesin/dextromethorphan)	**Blansett Pharmacal**
***Quintex Syrup** (phenylephrine/guaifenesin)	**Qualitest**
***Robitussin Cough & Congestion Liquid** (chlorpheniramine/pseudoephedrine/ dextromethorphan/guaifenesin/acetaminophen)	**Wyeth Consumer**
***Robitussin Cough & Cold Nightime** (chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin Cough & Allergy** (chlorpheniramine, dextromethorphan, phenylephrine	**Wyeth**
***Robitussin Cough & Cold CF** (dextromethorphan, guaifenesin, phenylephrine)	**Wyeth**
***Robtiussin Cold & Flu Nightime** (acetaminophen, chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin DM Liquid** (guaifenesin/dextromethorphan)	**Wyeth Consumer**
***Robitussin PE Syrup** (pseudoephedrine/guaifenesin)	**Wyeth Consumer**
***Robitussin Pediatric Drops** (guaifenesin/dextromethorphan/pseudoephedrine)	**Wyeth Consumer**
***Robitussin Pediatric Night Relief Liquid** (chlorpheniramine/dextromethorphan/ pseudoephedrine)	**Wyeth Consumer**
***Scot-Tussin Allergy Relief Formula Liquid** (diphenhydramine)	**Scot-Tussin**
***Scot-Tussin DM Liquid** (chlorpheniramine/dextromethorphan/guaifenesin)	**Scot-Tussin**
***Scot-Tussin Expectorant Liquid** (guaifenesin)	**Scot-Tussin**
***Scot-Tussin Original Syrup** (phenylephrine)	**Scot-Tussin**
***Scot-Tussin Senior Liquid** (guaifenesin/dextromethorphan)	**Scot-Tussin**
***Sildec Liquid** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec Syrup** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec-DM Drops** (brompheniramine/pseudoephedrine/carbinoxamine/dextromethorphan)	**Silarx**
***Sildec-DM Syrup** (brompheniramine/pseudoephedrine/ carbinoxamine/dextromethorphan)	**Silarx**
Siltussin DAS Liquid (guaifenesin)	**Silarx**
***Siltussin DM Syrup** (guaifenesin/dextromethorphan)	**Silarx**
***Siltussin DM DAS Cough Formula Syrup** (guaifenesin/dextromehtorphan)	**Silarx**
Siltussin SA Syrup (guaifenesin)	**Silarx**
***Simply Cough Liquid** (dextromehtorphan)	**McNeil Consumer**
***Sudatuss DM Syrup** (chlorpheniramine/dextromethorphan/pseudoephedrine)	**Pharmaceutical Generic**
***Tussafed Syrup** (chlorpheniramine/carbinoxamine/ pseudoephedrine/dextromethorphan)	**Everett**
***Tussafed-EX Syrup** (pseudoephedrine/dextromethorphan/guaifenesin)	**Everett**
***Tuss-DM Liquid** (chlorpheniramine/phenylephrine/guaifenesin/dextromethorphan	**Seatrace**
***Tussi-Organidin DM NR Liquid** (guaifenesin/dextromethorphan)	**Wallace**
***Tussi-Pres Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Kramer-Novis**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Tylenol Cold Children's Liquid** (chlorpheniramine/pseudoephedrine/acetaminophen)	McNeil Consumer
***Tylenol Cold Infants' Drops** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Tylenol Flu Children's Suspension** (chlorpheniramine/pseudoephedrine/ dextromethorphan/acetaminophen)	McNeil Consumer
***Tylenol Flu Night Time Max Strength Liquid** (acetaminophen/ doxylamine/ diphenhydramine/pseudoephedrine/dextromethorphan)	McNeil Consumer
***Tylenol Sinus Children's Liquid** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Vicks Dayquil Multi-symptom cold/flu relief** (acetaminophen, dextromethorphan, phenylephrine)	Procter & Gamble
***Vicks 44E Pediatric Liquid** (guaifenesin/dextromethorphan)	Procter & Gamble
***Vicks 44M Pediatric Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	Procter & Gamble
***Z-Cof DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	Zyber

Ear/Nose/Throat Products:

4-Way Saline Moisturizing Mist Spray	Bristol-Myers
Ayr Baby Saline Spray	Ascher, B.F.
Bucalcide Solution (benzocaine)	Seyer Pharmatec
Bucalcide Spray (benzocaine)	Seyer Pharmatec
Bucalsep Solution (benzocaine)	Gil
Bucalsep Spray (benzocaine)	Gil
Cepacol Sore Throat Liquid (benzocaine)	Combe
Gly-oxide Liquid (carbamide peroxide)	GlaxoSmithKline
Consumer Orasept Mouthwash/Gargle Liquid (benzocaine)	Pharmakon Labs
Zilactin Baby Extra Strength Gel (benzocaine)	Zila Consumer

Gastrointestinal Agents

Imogen Liquid (loperamide)	Pharmaceutical
Kaopectate (bismuth subsalicyate)	Ethex

Generic

Kaopectate Suspension (bismuth subsalicylate)	Pharmacia

Consumer

Liqui-Doss Liquid (mineral oil)	Ferndale

Hematinics

Irofol Liquid (iron)	Dayton

Alcohol-Free Products

Miscellaneous

Cytra-2 Solution (sodium citrate salts)	**Cypress**
Cytra-K Solution (sodium citrate salts)	**Cypress**
Emetrol Solution (phosphorated carbohydrate)	**Pharmacia Consumer**

Psychotropics

***Thorazine Syrup** (chlorpromazine)	**GlaxoSmithKline**

Topical Products

Aloe Vesta 2-N-1 Antifungal Ointment (miconazole)	**Convatec**
Fleet Pain Relief Pads (pramoxine)	**Fleet**
Neutrogena Acne Wash Liquid	**Neutrogena**
Neutrogena Antiseptic Liquid	**Neutrogena**
Neutrogena Clear Pore Gel	**Neutrogena**
Neutrogena T/Derm Liquid	**Neutrogena**
Neutrogena Toner Liquid	**Neutrogena**
Podiclens Spray (benzalkonium chloride)	**Woodward**
Sea Breeze Foaming Face Wash Gel	**Clairol**

Vitamins/Minerals/Supplements

Apetigen Elixir (vitamins A & E/multivitamin)	**Pharmaceutical Generic**
Genesupp-500 Liquid (multivitamin)	**Pharmaceutical Generic**
Genetect Plus Liquid (multivitamin/iron)	**Pharmaceutical Generic**
Multi-Delyn w/Iron Liquid (multivitamin/iron)	**Silarx**
Poly-Vi-Sol Drops (multivitamin)	**Mead Johnson**
Poly-Vi-Sol w/Iron Drops (multivitamin/iron)	**Mead Johnson**
Strovite Forte Syrup (multivitamin/iron/folic acid)	**Everett**
Supervite Liquid (multivitamin/B complex/folic acid/multivitamin)	**Seyer Pharmatec**
Suplevit Liquid (multivitamin/iron)	**Gil**
Tri-Vi-Sol Drops (multivitamin)	**Mead Johnson**
Tri-Vi-Sol w/Iron Drops (multivitamin/iron)	**Mead Johnson**
Vitafol Syrup (multivitamin/iron/folic acid/vitamin E/calcium salts)	**Everett**

Incidental Exposure Index

New markers for alcohol use, ethylglucuronide (EtG), ethylsulfate (EtS) and others, have added tremendous value to routine drug testing by their capacity to better document abstinence (allowing for more authoritative advocacy) and sensitively to detect early relapse (allowing for earlier assistance). Since these new markers are highly sensitive, it's important that individuals being tested try to avoid exposure to products containing alcohol that might cause positive tests. This issue is identical to that of avoiding poppy seeds to avoid a positive test for morphine. However, there are many more products containing alcohol. ***Please note that this list is not exhaustive, therefore it is recommended that patients check labels or with manufacturers before using.***

Possible Sources of Incidental Exposure

Foods

Foods can contain trace amounts or large quantities of alcohol. Avoid desserts and other foods cooked with or containing alcoholic beverages such as vodka, sherry, wine, etc. Also avoid foods containing significant amounts of vanilla extract (especially if added to drinks), wine vinegar, soy sauces and other condiments with alcohol content on their labels.

Hygiene Products

Many hygiene related products, such as mouthwashes, contain alcohol and should be avoided. For a comprehensive list of hygiene products that contain alcohol, please read the *Alcohol-Containing Products Table* on the following pages.

Over-the-Counter Medications

Over-the-counter medications, such as cough syrup and tinctures, contain alcohol and should be avoided. Please review the *Over-the-Counter Medications Alcohol Content Table* on the following pages for a more detailed breakdown of OTCs that contain alcohol.

Prescription Medications

Many prescription medications, including asthma inhalers, contain alcohol or ethanol. Always ask your health care provider prior to taking any prescription medications.

Other Sources of Alcohol

Alcohol can be found in many common products including communion wine and "alcohol-free" beer and wine. Recovering patients should also avoid products like hand sanitizers, deodorant sprays, cosmetics and insecticides that contain ethanol vapor and can be inhaled or absorbed through skin application.

Alcohol-Containing Products Table

The following is a list of products and their alcohol contents. Not all of these would actually be likely to be sources of incidental exposure and some would result in very toxic effects if there was much exposure (i.e. Clorox).

Product	*Alcohol %*
ABIN Primer & Sealer	35
Afta After Shave Skin Conditioner 3 OZ.	5-15
Afta Pre-Electric Shave Lotions	50-60
Ajax Antibacterial Dishwashing Liquid 19 OZ.	5-10
Ajax Dishwashing Liquid Antibacterial Hand Soap 38 OZ.	1-5
Aqua Mix Laminate Plus	<9
Aqua Mix Tile Plus More Cleaner-10/31/2000	<9
Ariel Liquid Laundry Detergent	1-5
Armor All Odor Eliminator	3-7
Armor All Odor Eliminator-01/01/2001	1-10
Arrid Total Gel-All Scents	7-12
Avon Black Suede After Shave	60-98
Avon Black Suede Cologne Spray	60-98
Avon Clearskin Targeted Blemish Remover	9.995
Avon Dreamlife Eau de Parfum Spray	60-98
Avon Far Away Sensual Embrace Eau de Parfum Spray	60-98
Avon Ginger Scents Spray Ginger Fresh Body Mist	60-98
Avon Haiku Eau de Parfum Spray	60-98
Avon Imari Eau de Cologne Spray	60-98
Avon Intrigue Cologne Spray	60-98
Avon Lil Hugs Gentle Splash	60-98
Avon Little Black Dress Eau de Parfum Spray	60-98
Avon Memorable Eau de Parfum Spray	60-98
Avon Mesmerize for Men Cologne Spray	60-98
Avon Midnight Frost Fragrance Spray	60-98
Avon Moisture Effective Eye Makeup Remover Lotion	60-98
Avon MUSK FOR BOYS	60-98
Avon NAIL EXPERTS Strong Results	21.74
Avon NATURALS Body Spray, Almond	60-98
Avon NATURALS Body Spray, Cucumber Melon	60-98
Avon NATURALS Body Spray, Gardenia	60-98
Avon NATURALS Body Spray, Lily	60-98
Avon NATURALS Body Spray, Peach	60-98
Avon NATURALS Body Spray, Plumeria	60-98
Avon NATURALS Body Spray, Raspberry	60-98

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Avon NATURALS Body Spray, Sea	60-98
Avon NATURALS Body Spray, Vanilla	60-98
Avon Night Evening Magic Cologne Spray	60-98
Avon Passion Dance for Men	60-98
Avon Passion Dance for Women	60-98
Avon Perceive Eau de Parfum Spray for Women	60-98
Avon Perceive For Men Cologne Spray	60-98
Avon Pink Suede Eau de Toilette Spray	60-98
Avon Planet Spa White Tea Energizing Face and Body Mist	60-98
Avon Prospect Eau de Toilette Spray	60-98
Avon Radiant Moments Body Spray	60-98
Avon RARE GOLD Eau de Parfum Spray	60-98
Avon RARE PEARLS Eau de Parfum Spray	60-98
Avon Simply Radiant Shimmering Body Spray	60-98
Avon Vintage Cologne Spray	60-98
Avon WILD COUNTRY After Shave	60-98
Avon WILD COUNTRY Cologne Spray	60-98
Avon Wild Country Outback After Shave Lotion	60-98
Avon Wild Country Outback Eau De Toilette Spray	60-98
Bath & Body Instant Anti-Bacterial Hand Gel-Freesia	60
Bay Rum After Shave Balm	30
Bold Liquid Laundry Detergent	1-5
Bravo Platinum Series Metered Air Freshener	15-25
Bulls Eye Clear Shellac	55
Cascade Crystal Clear Plus Shine Shield Rinse Agent 8.45 fl oz	3-7
Cheer Liquid Laundry Detergent	1-5
Clorox Dual Action Toilet Bowl Cleaner 1 Pt. 9 Fl. Oz. (Chambered Bottle)	1-5
Clorox Spring Mist Disinfecting Spray-Floral Fresh 18 Oz. (aerosol)	60-80
Cutter All Family Insect Repellent 2 Aerosol	35
Cutter All Family Insect Repellent Mosquito Repellent Pump Spray	39
Cutter Insect Repellent	17
Cutter Skinsations Insect Repellent 1, Aloe & Vitamin E, Clean Fresh Scent	50
Cutter Unscented Backwoods Insect Repellent, Water-Resistant Sport Formula, Aerosol	35
Cutter Unscented Backwoods Mosquito Wipes	29
Cutter Unscented Insect Repellent	37
Cutter Unscented Outdoorsman Insect Repellent II Pump Spray	44
Cutter Unscented Outdoorsman Insect Repellent, Water-Resistant Sport Formula, Aerosol	20

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
DAP Easy Bond Adhesive	1.0-5.0
Dawn Manual Pot and Pan Detergent	5-10
Dawn Manual Pot and Pan Detergent (Professional Line)	5-10
Deep Woods OFF!	50-60
Deep Woods Off! Pump Spray	30-40
Dermassage Dishwashing Hand Liquid - Regular	1-5
Downy Advanced w/Wrinkle Control Fabric Softener (Clean Breeze, Mountain Spring)	1-5
Downy Enhancer	1-5
Downy Enhancer (Invigorating Burst and Calming Mist)	1-5
Downy Premium Care	1-5
Dreft Liquid Laundry Detergent	1-5
Easy Off Heat Activated Microwave Wipes	5-10
Era Liquid Laundry Detergent	1-5
Fab Color Plus Ultra Power	1-5
Farnam Cologne & Deodorant for Pets	20
Febreze Air Effects 9.7 oz Blossoms and Breeze	3-7
Febreze Air Effects 9.7 oz Citrus and Light	3-7
Febreze Air Effects 9.7 oz Spring and Renewal	3-7
Febreze Concentrated Fabric Refresher	12-17
Febreze Fabric Refresher	1-5
Fire Up II Firestarter	<85
Gain Liquid Laundry Detergent	1-5
Giant Auto Dish Detergent 75 OZ BOX	1-5
Giant Pure Power Auto Dish Detergent Lemon 45 OZ BOX	1-5
Glade Fragrant Mist Country Garden	7-13
Glass Mates	4.0-6.0
Glass Mates-05/16/2000	4.0-6.0
HOUSE SAVER Pet Stain & Odor Remover	20
Invisible Shield Surface Protectant-04/11/2002	78
Ivory Snow Liquid Laundry Detergent	1-5
KimCare Instant Hand Sanitizer	60
Lady Speed Stick Clear Antiperspirant Deodorant Gel	15-20
Listerine Antiseptic Mouthwash	26.9
Listerine Cool Mint Antiseptic Mouthwash	23
Listerine Fresh Burst Antiseptic Mouthwash	23
Listermint Mouthwash	<10
Loctite Crafter's All Purpose Adhesive	3-5

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Loctite Fabric Glue	3-5
Loctite Outdoor Fixture Adhesive	1-5
LOreal Pumping Curls for Curly Hair	41
Lysol Brand Antibacterial Hand Gel	63
Lysol Brand Disinfectant Spray, Antibacterial, Original Scent	79.0
Lysol Brand II Disinfectant Plus Fabric Refresher 12 oz	85
Lysol Brand II Disinfectant Spray-Country Scent (aerosol)	79
Lysol Brand Sanitizing Wipes-Citrus Scent	8-10
Lysol Brand Sanitizing Wipes-Spring Waterfall 52 oz	8-10
Lysol Brand Scrubbing Wipes-Orange Breeze Scent	8-12
Martin Weber Blue Label Fixatif Spray	60-70
Martin Weber Cleaning Solution	31
Mr Muscle Pot & Pan Detergent	3-7
Nair Hair Remover Kit, Cold Wax Strips Pretreatment Towelette	5-20
New-Skin Liquid Bandage	5
Nilodor Air Freshener-Floral	0.5-3.5
Nilodor Carpet Care Deodorizing Spot/Stain Remover	2-6
Nilodor Deodorizing Carpet Extractor	2-6
Nilodor Odor Neutralizer	0.5-3.5
Nilotex Carpet Care	2-6
Off Skintastic Insect Repellent for Kids	>90
Off! Deep Woods for Sportsmen Insect Repellent IV, Aerosol	50-60
Off! Deep Woods Insect Repellent V Spray, Unscented	50-60
Off! Skintastic IV	90-95
Old English Furniture Wipes	4-8
Oust Air Sanitizer, Outdoor Scent	60-70
Oust Bathroom Citrus Scent Fan .40 oz.	40-60
Oust Bathroom Outdoor Scent Fan	40-60
Palmolive Original Hand Dishwashing Liquid	4.3
Paul Mitchell Freeze & Shine Super Spray	>60
Paul Mitchell Freeze & Shine Super Spray (New)	<60
Paul Mitchell Soft Sculpting Spray Gel	<20
Pine Power Disinfectant Cleaner	<5.0
Purell Instant Hand Sanitizer	62
Purell Instant Hand Sanitizer Dry Hands Formula	62
Purell Instant Hand Sanitizer Packets	62
Purell Instant Hand Sanitizer with Aloe, Moisturizers & Vitamin E	62
Purell Instant Hand Sanitizer, Original	62

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Purell Kids Own Berry Blast	62
Radio Shack 951 Low Residue Soldering Paste Flux	73
Radio Shack Cleaner/Degreaser	27
Radio Shack Professional Tape Head Cleaner	15-20
Rain X Marine Windshield Treatment	70-95
Rain X The Invisible Windshield Wiper	86
Rain-X Anti-Fog	70-99
Rain-X Windshield Wax	70-95
Repel Hunters' Insect Repellent with Earth Scent, 55 Percent DEET	<45
Repel Insect Repellent Family Formula Spray Pump, 23 Percent DEET	44
Repel Insect Repellent Scented Family Formula Aerosol, 23 Percent DEET	48.3
Repel Insect Repellent Sportsmen Formula Spray Pump, 25 Percent DEET	55
Repel Insect Repellent Sportsmen Max Formula, 40 Percent DEET	43.7
Repel Lemon Eucalyptus Insect Repellent Lotion	<10
Repel Lemon Eucalyptus Insect Repellent Spray Lotion	<10
Soft Soap Hand Sanitizer - Gel	60-65
Spic and Span 10X Concentrate Disinfecting All Purpose Spray	12-25
Spic and Span Floor and Multi Surface Cleaner	0-5
Spray N Wash Laundry Stain Remover	2-3
Static Guard	70-72
Survivor Lemon Eucalyptus Insect Repellent Lotion	<10
TEN O SIX Medicated Deep Pore Cleanser	<15
Time Mist Air Freshener W/Odor Counteractant	15-25
Ultra Downy Liquid Fabric Softener	1-5
Valspar One & Only Interior/Exterior Multi Purpose Flat Black Finish	5-10
Valspar One & Only Multi Purpose Gloss Enamel, Almond	5-10
Valspar One & Only Multi Purpose Gray Metal Primer	5-10
Viadent Advanced Care Rinse	5-10
Wet Ones Antibacterial Moist Towelettes, Citrus	9.6
Wet Ones Antibacterial Moist Towelettes, Travel Pack, Citrus	9.6
Wet Ones Antibacterial Portable Washcloths, Ultra	0-9.6
Wet Ones Kids Antibacterial Wipes, Wild Watermelon & Ballistic Berry	0-9.6
Wet Ones Moist Towelettes with Aloe, Travel Pac	0-10.5
Wet Ones Moist Towelettes with Vitamin E & Aloe	0-10.5
Wet Ones Portable Washcloths with Vitamin E & Aloe, Ultra	0-10.5
Wet Ones Ultra Portable Antibacterial Wash Cloths	9.6
Wet Ones, Antibacterial Moist Towelettes, Thick Cloths	9.6
Zep Tile and Terrazzo Cleaner	5-15

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Ambenyl	cough suppressant	Forest	5
Ambenyl-D	expectorant, nasal decongestant, cough suppressant	Forest	9.5
Anesol	oral antiseptic, anesthetic	Whitehall	70
AsbronG Elixir	anti-asthmatic	Sandoz	15
Bayer children's Cough Syrup	cough suppressant, nasal decongestant	Glenbrook	5
Benadryl Decongestant Elixir	antihistamine	Parke-Davis	5
Benadryl Elixir	antihistamine	Parke-Davis	14
Benylin Cough Syrup	cough suppressant	Parke-Davis	5
Benylin DM	cough suppressant	Parke-Davis	5
Bronkolixir	bronchodilator, decongestant	Winthrop	19
Cepacol/Cepacol Mint	mouthwash, gargle	Lakeside	14.5
Ce-Vi-Sol	vitamin C drops (infant)	Mead-Johnson	5
Cheracol D	cough suppressant, decongestant	Upjohn	4.75
Cheracol Plus	cough suppressant, decongestant	Upjohn	8
Chlor-Trimeton Allergy Syrup	antihistamine	Schering	7
Choedyl Elixir	bronchodilator	Parke-Davis	20
Colace Syrup	laxative	Mead-Johnson	1
Colgate Mouthwash	mouthwash/gargle	Colgate-Palmolive	15.3
CONTAC Nighttime	antihistamine, analgesic, cough suppressant, decongestant	SmithKline	25
Dilaudid Cough Syrup	cough suppressant, analgesic	Knoll	5
Dimetane Elixir	antihistamine	A. H. Robins	3
Dimetane Decongestant Elixir	antihistamine, decongestant	A. H. Robins	2.3
Dimetapp Elixir	decongestant, antihistamine	A. H. Robins	2.3
Diural Oral Suspension	diuretic, antihypertensive	Merck Sharp & Dohme	0.5
Donnatal Elixir	anti-spasmodic	A. H. Robins	23
Elixophyllin-Kl Elixir	anti-asthmatic	Forest	10
Feosol Elixir	iron supplement	SmithKline	5
Fergon Elixir	iron supplement	Winthrop	7
Geriplex-FS	vitamins (geriatric)	Parke-Davis	18
Geritol Liquid	vitamins	Beecham	12
Geritonic Liquid	vitamins	Geriatric	20
Gevrabon	vitamins	Lederle	18
Hycotuss	expectorant	DuPont	10
I.L.XB12 Elixir	iron supplement	Kenwood	8
Iberet Liquid	vitamins	Abbott	1

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Imodium A-D	anti-diarrheal	McNeil	5.25
Incremin	vitamins	Lederle	0.75
Indocin Oral Suspension	analgesic	Merck Sharp & Dohme	1
Kaochlor S-F	potassium supplement	Adria	5
Kaon-CL 20%	potassium/chloride supplement	Adria	5
Kaon Elixir	potassium supplement	Adria	5
Kay Ciel Oral Solution	potassium supplement	Forest	4
Klorvess 10% Liquid	potassium/chloride supplement	Sandoz	0.75
Lanoxin Elixir Pediatric	cardiac medication	Burrougfhs Wellcome	10
Lasix Oral Solution	diuretic	Hoechst-roussel	11.5
Listerine Antiseptic	mouthwash/gargle	Warner-Lambert	26.9
Lomotil Liquid	anti-diarrheal	G. D. Searle & Co.	15
Lufyllin Elixir	bronchodilator	Wallace	20
Marax-DF Syrup	bronchodilator	Roerig	5
May-Vita Elixir	vitamins	Mayrand, Inc.	13
Mediatric Liquid	estrogen replacement	Wyeth-Ayerst	15
Mellaril Oral Solution	antipsychotic	Sandoz	3-4.2
Mestinon Syrup	treatment of myasthenia ravis	Roche	5
Naldecon DX Pediatric Drops	decongestant	Bristol	0.6
Nicotinex	niacin supplement	Fleming & Co.	14
Niferex Elixir	iron supplement	Center Labs	10
Novahistine Elixir	antihistamine, decongestant	Lakeside	5
Novahistine Expectorant	cough suppressant, decongestant, expectorant	Lakeside	7.5
Nucofed Expectorant	cough suppressant, decongestant, expectorant	Beecham	12.5
Nucofed Pediaric Expectorant	cough suppressant, expectorant, decongestant	Beecham	6
Nu-Iron Elixir	iron supplements	Mayrand, Inc.	10
Nystex Oral Suspension	antifungal antibiotic	Savage	1
Organidin Elixir	expectorant	Wallace	21.75
PBZ Elixir	antihistamine	Geigy	12
Pamelor Oral Solution	anti-depressant	Sandoz	3-5
Peri Colace Syrup	laxative	Mead-Johnson	10
Permitil Oral Concentrate	anti-psychotic	Schering	1
Phenergan Syrup Plain	antihistamine	Wyeth-Ayerst	7
Phenergan Syrup Fortis	antihistamine	Wyeth-Ayerst	1.5
Phenobarbital Elixir	sedative	Rosane	13.5
Polaramine Syrup	antihistamine	Schering	6

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Poly-Histine Elixir	cough suppressant	Bock	4
Prolixin Elixir	anti-psychotic	Princeton	14
Quelidrine Syrup	cough suppressant	Abbott	2
Robitussin	expectorant	A. H. Robins	3.5
Robitussin A-C	cough suppressant, expectorant	A. H. Robins	3.5
Robitussin CF	cough suppressant, decongestant, expectorant	A.H. Robins	3.5
Robitussin DAC	expectorant, decongestant, cough suppressant	A. H. Robins	1.9
Robitussin Night Relief	analgesic, cough suppressant, decongestant	A. H. Robbins	25
Robitussin PE	decongestant, expectorant	A. H. Robbins	1.4
Sandimmune	immunosuppressant	Sandoz	12.5
Scot-Tussin Sugar-Free Expectorant	expectorant	Scott-Tussin	3.5
Sominex Liquid	sleep aid	Beecham	10
Sudafed Cough Syrup	decongestant	Burroughs Wellcome	2.4
Tacaryl Syrup	antihistamine	Westwood	7.37
Tagamet Liquid	ulcer medication	Smith Kline & French	2.8
Tavist Syrup	antihistamine	Sandoz	5.5
Theo-Organidin Elixir	bronchodilator, expectorant	Wallace	15
Triaminic Expectorant	expectorant, decongestant	Sandoz	5.5
Tussar-2	cough suppressant	Rorer	5
Tussar SF	cough suppressant	Rorer	12
Tussend	cough suppressant	Lakeside	5
Tussend Expectorant	cough suppressant, decongestant, expectorant	Lakeside	12.5
Tylenol Adult Liquid Pain Reliever	analgesic	McNeil	7
Tylenol Cold Medication Liquid	analgesic, decongestant, cough suppressant, antihistamine	McNeil	7
Tylenol with Codeine Elixir	analgesic	McNeil	7
Vicks Daycare Liquid	decongestant, analgesic, expectorant, cough suppressant	Richardson-Vicks	10
Vicks Formula 44	cough suppressant, antihistamine	Richardson-Vicks	10
Vicks Formula 44D	cough suppressant, decongestant	Richardson-Vicks	10
Vicks Formula 44M	cough suppressant, decongestant, analgesic	Richardson-Vicks	20
Vicks Nyquil	decongestant, cough suppressant, antihistamine, analgesic	Richardson-Vicks	25

Products Containing Alcohol

Please note: Some prescription nasal sprays used for allergic rhinitis and some other forms of nasal/sinus congestion contain alcohol. Alcohol-containing nasal sprays that should be avoided by recovering persons, especially those taking Antabuse, include Flonase and Nasonex nasal sprays. The majority of mouthwashes contain alcohol also. These should all be avoided.

5% Alcohol (10-Proof)

Diphenhydramine Elixir

Benylin Cough Syrup

Cheracol-D Cough Syrup (guaifenesin/dextromethorphan)

Dihstine DH Elixir
(chlorpheniramine/pseudoephedrine/codeine)

Dilaudid Cough Syrup (hydromorphone)

Dramamine Liquid (dimenhydrinate)

Feosol (iron) Elixir

Imodium A-D (loperamide)

Kaon Liquid (potassium)

Kay Ciel Liquid (potassium)

Guiatuss AC Syrup (guaifenesin/codeine)

Phenergan VC Syrup (promethazine/phenylephrine)

Tussend Syrup
(guaifenesin/chlorpheniramine/pseudoephedrine/hydrocodone)

Tylenol Extra Strength Liquid

Tylenol with Codeine Elixir

Vicks 44 D (dextromethorphan/pseudoephedrine)

Vicks 44 E (guaifenesin/dextromethorphan)

10% Alcohol (20-Proof)

Excedrin PM Liquid
(acetaminophen/diphenhydramine)

Geritol Tonic Liquid (multivitamin)

Hycotuss Expectorant Syrup
(hydrocodone/guaifenesin)

Niferex Elixir (iron)

Nucofed Expectorant Syrup
(guaifenesin/pseudoephedrine/codeine)

Nu-Iron Elixir (iron)

Vicks Nyquil
(doxylamine/pseudoephedrine/dextromethorphan/acetaminophen)

Vicks Formula 44M
(chlorpheniramine/pseudoephedrine/dextromethorphan/acetaminophen)

15% Alcohol (30-Proof)

Cepacol Mouthwash

Gerivite Elixir (multivitamin)

Lomotil Liquid (diphenoxylate/atropine)

20% Alcohol (40-Proof)

Gevrabon Liquid (vitamins)

Listerine Mouthwash (flavored)

Lufyllin Elixir (theophylline)

Theophylline Elixir

25% Alcohol (50-Proof)

Listerine Mouthwash (regular)

N'ice Throat Spray

TALBOTT RECOVERY CAMPUS

Medication Guide

For A Safe Recovery

A guide to maintaining sobriety while receiving treatment for other health problems.

Revision 2.0 -June 2014

Table of Contents

Introduction

From the Talbott Recovery Campus

Welcome to the Talbott Recovery Campus guide for a safe and sustained recovery. This document was developed through a collaborative effort between some of the best minds in addiction care today and will help you make wise decisions, ensuring that medications you may be prescribed and incidental exposure to alcohol do not threaten your hard won recovery.

This guide is divided into three sections and is based on the drug classification system developed nearly 20 years ago by Dr. Paul Earley and recently expanded on by Bruce Merkin, M.D., Renee Enstrom, Nicholas Link and the staff at Glenbeigh hospital. Part one provides a way of categorizing medications according to their safety. Part two offers a list of liquid medications that do NOT contain alcohol. Section three was developed by Greg Skipper, M.D., FASAM and provides a list of common household products that contain ethyl alcohol and could produce a false positive on testing for alcohol. Avoiding these products will decrease the likelihood you will absorb or ingest small quantities of alcohol that could sensitize your system and threaten recovery.

Please remember that this guide is only intended as a quick reference and never as a substitute for the advice of your own personal physician. It is essential that you inform all of your personal physicians, dentists and other health care providers of your chemical dependency history so that medications can be prescribed safely and appropriately when they are deemed necessary. Never discontinue or make any changes in the doses of medication that you may have been prescribed. Doing so may result in unexpected problems such as withdrawal reactions, which in some cases can be life-threatening. The bottom line is that a recovering addict or alcoholic needs to become a good consumer. Remember that "Recovery Is Its Own Reward." Being healthy and regaining a happy life is your responsibility!

How to Use this Guide

There are many types of medications that may present a hazard to a person beginning the journey of recovery from chemical dependency. These include prescription and over-the-counter medications. The danger is not always that a recovering addict may develop a new addiction (though this certainly can happen), but that one can be led back into dependence on their drug of choice. The latest scientific research has proven that all the dependence-producing drugs act on the brain in the same way to produce addiction, despite having different effects or a different kind of "high" when taken.

In addition, if urine drug screening is part of the recovering person's continuing treatment program, use of many types of medications can result in falsely positive tests for the more highly addictive classes of drugs, resulting in negative consequences. Therefore, it is very important for a recovering person to learn about the different types of medications and drugs, as well as which ones present a special risk to continuing recovery and sobriety. The commonly available medications and drugs are divided into three classes – A, B and C – to indicate three levels of risk.

Class A drugs must be avoided completely, as they are well known to produce addiction and are the most dangerous of all. Only under very unusual conditions can Class A drugs be taken by a recovering addict or alcoholic, and only when given by a physician or dentist and with the consent of the addiction medicine physician that follows your care. These exceptional circumstances can include severe illness and injuries, including major surgery, car accidents and other trauma, and tests or procedures that can only be done under sedation or anesthesia. Medication treatments for certain psychiatric conditions are in this category as are medications used for drug detoxification. The street names for relevant drugs are also included in Class A.

The medications in Class B are also potentially dangerous, especially when taken by recovering persons without the guidance of a physician or another health care professional. However, under certain circumstances, the Class B group can be taken safely under a physician's care. We strongly urge you to have an addiction medicine specialist follow your treatment when you are prescribed these medications.

Class C medications are generally safe from the point of view of addiction recovery. However, overuse of any medication, even the common over-the-counter remedies, can result in unwanted side effects. People who have struggled with drug addiction or alcoholism must remain aware of the tendency to look for external solutions for internal problems and should avoid taking any of these medications on their own in order to medicate emotions and feelings. The tools of recovery, including participation at 12-Step fellowship meetings, working the Steps, or talking with a sponsor, counselor or doctor, provide safe and healthy ways to deal with the strong feelings that can come up at any time in early sobriety.

The three classes of medications that appear on the following pages include both the brand name (i.e. "Valium"), as well as the generic name (i.e. "diazepam"), as the majority of prescription bottles are labeled with the generic name. On the following pages, look for the brand name listed first, followed by the (generic name) in parentheses. For street drugs, the common name is listed first, and the chemical name or street name is in parentheses. For each drug group in Class A and B, there is also a brief explanation of the dangers associated with taking the medication or street drug. At the end of the document there are two reference guides. The first is a list of alcohol-free products grouped by therapeutic category. The manufacturer is listed next to each product name. The second is the *Incidental Exposure Index*, which details common OTCs and products that contain alcohol.

Class A Drugs
Absolutely Avoid

Alcohol:

Ale
Beer (including "near bear" & "non-alcoholic" forms)
Brandy
Liqueur
Malt Beverage
Whiskey
Wine
Wine Cooler

Alcohol consumption reduces social inhibitions and produces pleasure and a sense of well-being. It is a stimulant (raises blood pressure and heart rate) and a depressant. Alcohol affects the brain's reward pathways and appears to be related to interactions with dopamine, GABA, serotonin, opioid and NMDA neurotransmitter systems. The "non-alcohol" or "NA" forms of beer should not be consumed because there is a small amount of alcohol present and research shows that smell may be enough to trigger cravings and a subsequent relapse among certain alcoholics. Please note that there is a variety of cough and cold preparations that contain alcohol and that medications which can be taken in tablet form will not contain ethyl alcohol. Certain topical products, soft-gels and capsules contain ethyl alcohol and should be avoided. Please refer to the table at the end of the document for a list of alcohol-containing products to avoid.

Antitussives/Expectorants:

Ambenyl (codeine/bromodiphenhydramine)
Duratuss HD (hydrocodone/dextromethorphan)
Guiatuss (codeine/pseudoephedrine/guaifenesin)
Hycodan Tablets (hydrocodone/homatropine)
Hycodan Syrup (hydrocodone/homatropine)
Hycomine (hydrocodone/chlorpheniramine/ phenylephrine/acetaminophen/caffeine)
Hycotuss (hydrocodone/guaifenesin)
Hydromet (hydrocodone/homatropine)
Mytussin (codeine/pseudoephedrine/guaifenesin)
Nucofed (codeine/pseudoephedrine/guaifenesin)
Phenergan with Codeine (codeine/promethazine)
Robitussin AC (codeine/guaifenesin)
Tussionex PennKinetic (hydrocodone/chlorpheniramine)
Vicodin Tuss (hydrocodone/guaifenesin)

Any cough medications containing narcotics such as codeine or hydrocodone should not be used. These medications bind to opiate receptors in the central nervous system, altering the perception of and response to pain and produce generalized central nervous system depression and may alter mood or cause sedation.

Barbiturates:

Amytal (amobarbital)
Barbita (phenobarbital)
Butisol (butabarbital)
Donnatal (phenobarbital/atropine/hyoscyamine/ scopolamine)
Esgic (acetaminophen/butalbital/caffeine)
Fioricet (butalbital/acetaminophen/caffeine)
Fiorinal (butalbital/aspirin/ caffeine)
Nembutal (pentobarbital)
Seconal (secobarbital)

These medications can produce central nervous system depression ranging from mild (sedation) to hypnotic (sleep induction). As the dose is increased, coma and death can occur. These medications can also lead to an unusual excitatory response in some people.

Class A Drugs
Absolutely Avoid

Benzodiazepines:

Ativan (lorazepam)
Centrax (prazepam)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Restoril (temazepam)
Serax (oxazepam)
Tranxene (chlorazepate)
Valium (diazepam)
Versed (midazolam)
Xanax (alprazolam)

These medications can produce an immediate change in mood or affect and can cause central nervous system depression (dose related) resulting in sedation, dizziness, confusion or ataxia, which may impair physical and mental capabilities. Abrupt discontinuation or a large decrease in dose can lead to seizures, coma or death.

Hallucinogens:

Cannabis (grass, green marijuana, pot, weed)
DMT (dimethyltryptamine)
Ketamine (special K)
LSD (acid, blotter, paper, sunshine, window pane)
Kratum (Mitragyna speciosa-ketum, kratom or kratum, Thai)
Marinol (dronabinol)
MDMA (E, eckies, ecstasy, love drug, X, XTC)
Mescaline (peyote)
PCP (angel dust, phencyclidine)
Psilocybin (magic mushroom, 'shrooms)
2-CB
5-MeO-DIPT (foxy methoxy)
STP (DOM)

Hallucinogens act in the central nervous system. Using these substances can possibly lead to memory disturbances, psychosis and vivid hallucinations. Marinol is the psychoactive substance in marijuana and may cause withdrawal symptoms if stopped suddenly. *The above is only a partial list of Hullucinogens.

Inhalants:

Aerosols (hair sprays, deodorants)
Airplane Glue
Amyl Nitrate (poppers)
Butyl Nitrate (room deodorizer)
Gases (ether, chloroform, nitrous oxide, butane lighters, propane tanks, whipped cream dispensers)
Nail Polish Remover (acetone)
Paint (butane, propane, toluene)
Solvents (paint thinner, gasoline, glue, correction fluid, felt tip marker)
Varnish (xylene, toluene)

Inhalants are central nervous system depressants. Use of inhalants can cause sedation and loss of inhibitions possibly leading to liver, kidney, nerve, heart, brain, throat, nasal and lung damage up to and including coma and death.

Class A Drugs
Absolutely Avoid

Opioids:

Actiq (fentanyl oral transmucosal)
Buprenex (buprenorphine)
Combunox (oxycodone/ibuprofen)
Darvocet (propoxyphene napsylate/acetaminophen)
Darvon (propoxyphene hydrochloride)
Demerol (meperidine)
Dilaudid (hydromorphone)
Dolophine (methadone)
Duragesic (fentanyl transdermal)
Endocet (oxycodone/acetaminophen)
Heroin (down, H, horse, smack)
Kadian (morphine sulfate)
Lorcet (hydrocodone/acetaminophen)
Lortab (hydrocodone/acetaminophen)
Methadose (methadone)
MS Contin (morphine sulfate)
Norco (hydrocodone/acetaminophen)
Nubain (nalbuphine HCl)
OxyContin (oxycodone)
OxyIR (oxycodone)
Percocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Roxanol (morphine sulfate)
Roxicet (oxycodone/acetaminophen)
Roxicodone (oxycodone)
Soma Compound with Codeine (codeine/carisoprodol/aspirin)
Stadol (butorphanol)
Suboxone (buprenorphine/naloxone)
Subutex (buprenorphine)
Talacen (pentazocine/acetaminophen)
Talwin (pentazocine lactate)
Tylenol #2, #3 or #4 (codeine/acetaminophen)
Ultram (tramadol) (a non-opioid analgesic)
Vicodin (hydrocodone/acetaminophen)

Opioids bind to opiate receptors in the central nervous system causing inhibition of ascending pain pathways and altering the perception of and response to pain. Generalized central nervous system depression is also produced. Tolerance or drug dependence may result from extended use. Buprenorphine binds to mu receptors in the brain leading to a suppression of withdrawal and cravings but also feeling of euphoria. Most of the drugs in this class have the potential for drug dependency and abrupt cessation may precipitate withdrawal.

Gastrointestinal (Anti-Diarrheals):

Lomotil (atropine/diphenoxylate)
Motofen (atropine/difenoxin)

Diphenoxylate is a member of the opioid class of drugs. Atropine is added to discourage abuse for recreational purposes. At recommended doses, the atropine causes no effects but in larger doses, unpleasant symptoms are experienced. These medications should not be used because high doses may cause physical and psychological dependence with prolonged use.

Other Central Nervous System Depressants:

GHB (G, gamma-hydroxybutyrate, everclear)

This category depresses the central nervous system possibly leading to confusion, psychosis, paranoia, hallucinations, agitation, depression, seizures, respiratory depression, decreases in level of consciousness, coma and death.

Other Sedative-Hypnotics:

Ambien (zolpidem)
Doriden (glutethimide)
Librax (chlordiazepoxide/clidinium)
Lunesta (eszopiclone)
Midrin (acetaminophen/dichloralphenazone/ isometheptene)
Miltown (meprobamate)
Noctec (chloral hydrate)
Placidyl (ethchlorvynol)
Quaalude, Sopor (methaqualone)
Soma (carisoprodol)
Soma Compound (carisoprodol/aspirin)
Sonata (zaleplon)

These drugs act on the central nervous system and have the potential for drug dependency and abuse. Withdrawal symptoms can be seen if stopped suddenly.

Stimulants:

Adderall (amphetamine/dextroamphetamine)
Adipex-P (phentermine)
Cocaine (blow, coke, crack, rock, snow, white)
Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine (dextroamphetamine)
Fastin (phentermine)
Focalin (dexmethylphenidate)
Meridia (sibutramine)
Metadate (methylphenidate)
Methamphetamine (crank, crystal meth, glass, ice, speed)
Methylin (methylphenidate)
Preludin (phenmetrazine)
Ritalin (methylphenidate)
Tenuate (diethylpropion)

Stimulants cause physical and psychological addiction, impair memory and learning, hearing and seeing, speed of information processing, and problem-solving ability.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Addiction Treatments:

*****NOTE: Although the medications listed in this *Addiction Treatments* section are specifically intended to be taken for prevention of relapse to dependence upon one or more drugs, none of them are habit-forming or addictive themselves and should therefore be considered safe for recovering people to take. However, their proper use in the context of a recovery program requires monitoring by a health care professional, and it is for this reason that we place them in Class B.*****

Antabuse (disulfiram)
Campral (acamprosate)
Catapres (clonidine)
Chantix (varenicline)
Revia (naltrexone)
Symmetrel (amantadine)
Zyban (bupropion)

Naltrexone may precipitate intense withdrawal symptoms in patients addicted to opiates. Clonidine acts via autoreceptors in the locus coeruleus to suppress adrenergic hyperactivity there that is involved in the expression of the opioid withdrawal syndrome. Disulfiram is dangerous if taken with alcohol. Amantadine can cause decreased mental alertness or altered coordination. Chantix and Zyban are medications to help with nicotine (cigarettes, cigars, chewing tobacco, snuff) addiction.

Cough and Cold Preparations:

Antihistamines (Sedating)

Atarax (hydroxyzine hydrochloride)
Benadryl (diphenhydramine) OTC
Chlor-Trimeton (chlorpheniramine) OTC
Dimetane (brompheniramine) OTC
Efidac (chlorpheniramine) OTC
Periactin (cyproheptadine)
Polarmine (dexchlorpheniramine)
Tavist (clemastine) OTC
Teldrin (chlorpheniramine) OTC
Vistaril (hydroxyzine pamoate)

Sedating antihistamines should be used with caution because they have the potential to alter judgment and cause fatigue or sedation.

Antitussives/Expectorants

Benylin Cough (dextromethorphan) OTC
Comtrex (dextromethorphan) OTC
Contac (dextromethorphan) OTC
Delsym (dextromethorphan) OTC
Mucinex DM (dextromethorphan/guaifenesin) OTC
Nyquil (dextromethorphan/alcohol) OTC
Phenergan DM (promethazine/dextromethorphan)
Robitussin DM (dextromethorphan/guaifenesin)
Vicks Formula 44D (dextromethorphan) OTC

Any preparation containing dextromethorphan should be used with caution because dextromethorphan acts on opioid receptors in the brain. Respiratory depression and perceptual distortions can also be seen in those people taking large doses.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Decongestants (Many are Combination Products)

Actifed (pseudoephedrine/triprolidine) OTC
AH-chew D (phenylephrine) OTC
Alavert D (loratadine/pseudoephedrine) OTC
Allegra D (fexofenadine/pseudoephedrine)
Benzedrex Nasal Inhaler (propylhexamine) OTC
Bromfed (phenylephrine/brompheniramine)
Bromfed DM (pseudoephedrine/ brompheniramine/dextromethorphan)
Cardec DM (pseudoephedrine/ carbinoxamine/dextromethorphan)
Clarinex D (desloratadine/pseudoephedrine)
Claritin D (loratadine/pseudoephedrine) OTC
Deconamine SR (pseudoephedrine/ chlorpheniramine) OTC
Dimetapp (pseudoephedrine/brompheniramine)OTC
Duratuss (pseudoephedrine/guaifenesin)
Entex LA (phenylephrine/guaifenesin)
Entex PSE (pseudoephedrine/guaifenesin)
Humibid DM (pseudoephedrine/ dextromethorphan/ potassium guaiacolsulfonate)
Mucinex D (pseudoephedrine/guaifenesin) OTC
Nalex-A (phenylephrine) OTC
Novafed (pseudoephedrine) OTC
Profen (pseudoephedrine) OTC
Prolex-D (phenylephrine) OTC
R-Tannate Pediatric (phenylephrine/ chlorpheniramine/pyrilamine)
Rondec (phenylephrine/chlorpheniramine)
Rondec DM (phenylephrine/chlorpheniramine/ dextromethorphan)
Rynatan-S (phenylephrine/chlorpheniramine/ pyrilamine)
Semprex-D (pseudoephedrine/acrivastine)
Sinutuss DM (phenylephrine) OTC
Sudafed (pseudoephedrine) OTC
Tussafed-EX (phenylephrine) OTC
Zyrtec D (cetirizine/pseudoephedrine)

Decongestants should be used with caution because they are stimulating and can trigger relapse.

Nasal Sprays

Afrin (oxymetazoline) OTC
Astelin (azelastine)
Dristan (oxymetazoline) OTC
Flonase (fluticasone)
Nasacort AQ or HFA (triamcinolone)
Nasonex (mometasone)
Neo-synephrine (phenylephrine) OTC
Nostrilla (oxymetazoline) OTC
Rhinocort Aqua (budesonide)
Vicks Nasal Inhaler (desoxyephedrine) OTC
Vicks Sinex (phenylephrine) OTC
4-Way Nasal Spray (phenylephrine) OTC

All OTC nasal sprays should be used for a short period of time. If used for a long period of time symptoms may worsen. Use for a maximum of 5 days. Intranasal corticosteroids (non-OTC) may cause a reduction in growth velocity in pediatric patients.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Muscle Relaxants:

Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Parafon Forte (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Zanaflex (tizanidine)

Muscle relaxants can cause central nervous system depression (sedation, dizziness), which may impair physical or mental abilities.

Neuropathic Pain:

Lyrica (pregabalin)

Lyrica acts in the central nervous system as a depressant and can lead to withdrawal symptoms upon discontinuation. It also produces euphoria in certain individuals.

Sleep Aids:

Excedrin PM (diphenhydramine) OTC
Nytol (diphenhydramine) OTC
Sleep-eze (diphenhydramine) OTC
Sominex (diphenhydramine) OTC
Tylenol PM (diphenhydramine/acetaminophen) OTC
Unisom (diphenhydramine) OTC

Sleep aids act in the central nervous system and can alter judgement and cause sedation.

Others:

Asthma

Primatene Mist (epinephrine) OTC

Primatene Mist can cause nervousness, restlessness, sleeplessness, palpitations, tachycardia, chest pain, muscle tremors, dizziness and flushing.

Steroids

Decadron (dexamethasone)
Deltasone (prednisone)
Medrol (methylprednisolone)

It is important to take steroids exactly as directed. Long term use requires a taper off of the drug. Steroid use can decrease the immune system leading to increased infections. Insomnia, nervousness and a variety of other side effects are also common.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Asthma/COPD/Pulmonary (Inhaled Corticosteroids/Long-Acting Beta 2 Agonists)

Advair Diskus (fluticasone/salmeterol)
Azmacort (traimcinolone)
Flovent (fluticasone)
Pulmicort (budesonide)
Serevent Diskus (salmeterol)
QVAR (beclomethasone)

Particular care is required when patients are transferred from systemic corticosteroids to inhaled products due to possible adrenal insufficiency or withdrawal from steroids, including an increase in allergic symptoms. Regular use may suppress the immune system. Orally-inhaled corticosteroids may cause a reduction in growth velocity in pediatric patients. Advair and Serevent can cause central nervous system excitement.

Gastrointestinal (Constipation)

Dulcolax (bisacodyl) OTC
Ex-Lax (senna) OTC
Senokot (senna) OTC

Continued use of laxatives can lead to dependency for colon function. Use for only a short period of time.

Gastrointestinal (Nausea/Vomiting)

Compazine (prochlorperazine)
Phenergan (promethazine)
Tigan (trimethobenzamide)
Zofran (ondansetron)

These medications affect the central nervous system and can cause sedation.

Vertigo/Motion Sickness

Antivert (meclizine)
Dramamine (dimenhydrinate) OTC
Transderm Scop (scopolamine)

These medications affect the central nervous system and can cause dizziness, drowsiness or blurred vision.

Class C Drugs
Generally Safe to Take

Alzheimer's:
Aricept (donepezil)
Exelon (rivastigmine)
Namenda (memantine)
Razadyne (galantamine)

Analgesics (Migraine):
Amerge (naratriptan)
Axert (almotriptan)
Frova (frovatriptan)
Imitrex (sumatriptan)
Maxalt (rizatriptan)
Relpax (eletriptan)
Zomig (zolmitriptan)

Analgesics (Other):
Tylenol (acetaminophen) OTC

Anti-Convulsants (Also Mood Stabilizers):
Carbatrol (carbamazepine)
Depakote (divalproex sodium)
Dilantin (phenytoin)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zonegran (zonisamide)

Antihistamines (Non-sedating):
Alavert (loratadine) OTC
Allegra (fexofenadine)
Clarinex (desloratadine)
Claritin (loratadine) OTC
Zyrtec (cetirizine)

Antibiotics/Antivirals:
Amoxil (amoxicillin)
Augmentin (amoxicillin/clavulanate)
Avelox (moxifloxacin)
Bactrim (sulfamethoxazole/trimethoprim)
Biaxin (clarithromycin)
Ceclor (ceflacor)
Ceftin (cefuroxime)
Cefzil (cefprozil)
Cipro (ciprofloxacin)
Cleocin (clindamycin)
Diflucan (fluconazole)
Doryx (doxycycline)
Duricef (cefadroxil)
E-Mycin (erythromycin)
Flagyl (metronidazole)
Keflex (cephalexin)
Ketek (telithromycin)
Levaquin (levofloxain)
Lorabid (loracarbef)
Macrobid (nitrofurantoin monohydrate/macrocrystals)
Macrodantin (nitrofurantoin macrocrystals)
Minocin (minocycline)
Omnicef (cefdinir)
Pen-Vee K (penicillin)
Relenza (zanamavir)
Sporanox (itraconazole)
Sumycin (tetracycline)
Tamiflu (oseltamavir)
Tequin (gatifloxacin)
Valtrex (valacyclovir)
Vantin (cefpodoxime)
Vibramycin (doxycycline)
Zithromax (azithromycin)
Zovirax (acyclovir)

Class C Drugs
Generally Safe to Take

Anti-Parkinsonians:
Mirapex (pramipexole)
Requip (ropinirole)
Sinemet (carbidopa/levodopa)

Antitussives/Expectorants:
Humibid LA (guaifenesin/potassium guaiacolsulfonate)
Mucinex (guaifenesin) OTC
Tessalon Perles (benzonatate)

Asthma/COPD/Pulmonary:
Accolate (zafirlukast)
Atrovent (ipratropium)
Combivent (albuterol/ipratropium)
Proventil/Ventolin (albuterol)
Singulair (montelukast)
Spiriva (tiotropium)
Theo-24 (theophylline)
Xopenex (levalbuterol)

Benign Prostatic Hypertrophy (Also Cardiovascular):
Cardura (doxazosin)
Flomax (tamsulosin)
Hytrin (terazosin)
Proscar (finasteride)

Cardiovascular (Antihypertensives, Anticoagulants, Antiplatelets, Cholesterol Lowering, Diuretics):
Accupril (quinapril)
Aldactone (spironolactone)
Altace (ramipril)
Aspirin
Atacand (candesartan)
Avalide (irbesartan/hydrochlorothiazide)
Avapro (irbesartan)
Benicar (olmesartan)
Betapace (sotalol)
Bumex (bumetadine)
Calan (verapamil)
Cardizem (diltiazem)
Coreg (carvedilol)
Coumadin (warfarin)
Cozaar (losartan)
Crestor (rosuvastatin)
Demadex (torsemide)
Diovan (valsartan)
Dyazide (hydrochlorothiazide/triamterene)
Heparin
Hydrodiuril (hydrochlorothiazide)
Hyzaar (losartan/hydrochlorothiazide)
Imdur (isosorbide mononitrate)
Inderal (propranolol)
Isordil (isosorbide dinitrate)
Lanoxin (digoxin)
Lasix (furosemide)
Lipitor (atorvastatin)
Lopid (gemfibrozil)
Lopressor (metoprolol)
Lotensin (benazepril)
Lotrel (amlopidine/benazepril)
Lovenox (enoxaparin)
Monopril (fosinopril)
Niaspan (Niacin)
Nitro-Bid (nitroglycerin)
Norvasc (amlopidine)
Plavix (clopidogrel)
Pravachol (pravastatin)
Prinivil (lisinopril)
Sular (nisoldipine)
Tenormin (atenolol)
Tricor (fenofibrate)
Vasotec (enalapril)
Vytorin (ezetimibe/simvastatin)
Zestril (lisinopril)
Zetia (ezetimibe)
Zocor (simvastatin)

Class C Drugs
Generally Safe to Take

Diabetes Mellitus:
Actos (pioglitazone)
Amaryl (glimepiride)
Avandia (rosiglitazone)
Diabeta (glyburide)
Glucophage (metformin)
Glucotrol (glipizide)
Humalog (insulin lispro)
Humulin L,N,R,U (insulin)
Lantus (insulin glargine)
Novolin 70/30, N or R (insulin)
Novolog (insulin aspart)

Erectile Dysfunction:
Cialis (tadalafil)
Levitra (vardenafil)
Viagra (sildenafil)

Gastrointestinal (Antacids, Anti-diarrheals, Anti-Spasmosdics, Anti-Ulcers, Constipation, Nausea/ Vomiting):
Aciphex (rabeprazole)
Bentyl (dicyclomine)
Colace (docusate sodium) OTC
Emetrol (phosphorylated carbohydrate) OTC
Imodium (loperamide) OTC
Kaopectate (bismuth subsalicylate) OTC
Maalox OTC
Mylanta OTC
Nexium (esomeprazole)
Pepcid (famotidine) OTC
Pepto-Bismol (bismuth subsalicylate) OTC
Prevacid (lansoprazole)
Prilosec (omeprazole) OTC
Protonix (pantoprazole)
Reglan (metoclopramide)
Simethicone OTC
Tums OTC
Zantac (ranitidine) OTC

Genitourinary:
Detrol (tolterodine)
Ditropan (oxybutinin)

Glaucoma:
Alphagan P (brimonidine)
Azopt (brinzolamide)
Cosopt (dorzolamide/timolol)
Lumigan (bimatoprost)
Timoptic (timolol)
Travatan (travoprost)
Trusopt (dorzolamide)
Xalatan (latanoprost)

Gout:
Zyloprim (allopurinol)

Nasal Sprays:
Atrovent (ipratropium)
Ayr (saline) OTC
HuMist (saline) OTC
NaSal (saline) OTC
NasalCrom (cromolyn) OTC
Ocean Spray (saline) OTC

Class C Drugs
Generally Safe to Take

Non-Steroidal Anti-Inflammatory Drugs:
Advil (ibuprofen) OTC
Aleve (naproxen) OTC
Anaprox (naproxen)
Cataflam (diclofenac potassium)
Daypro (oxaprozin)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Motrin (ibuprofen) OTC
Naprosyn (naproxen)
Orudis (ketoprofen)
Relafen (nabumetone)
Toradol (ketorlac)
Voltaren (diclofenac sodium)

COX-2 inhibitors:
Celebrex (celecoxib)

Osteoporosis (Calcium Metabolism):
Actonel (risedronate)
Boniva (ibandronate)
Evista (raloxifene)
Fosamax (alendronate)

Psychotropics:
Abilify (aripiprazole)
Buspar (buspirone)
Celexa (citalopram)
Clozaril (clozapine)
Cymbalta (duloxetine)
Depakote (divalproex sodium)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Eskalith (lithium)
Geodon (ziprasidone)
Haldol (haldoperidol)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Risperdal (risperidone)
Seroquel (quetiapine)
Serzone (nefazodone)
Sinequan (doxepin)
Sinequan (doxepin)
Strattera (atomoxetine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Zyprexa (olanzapine)

Sleep Aid:
Rozerem (ramelteon)

Thyroid:
Armour thyroid (thyroid desiccated)
Levothroid (levothyroxine)
Levoxyl (levothyroxine)
Synthroid (levothyroxine)

Alcohol-Free Products

The following is a selection of alcohol-free products grouped by therapeutic category. The list is not comprehensive. Manufacturers change product ingredients and brand names frequently. Always check product labeling for definitive information on specific ingredients. Manufacturers are listed after each product name. Please note that some of these medications, while alcohol-free, do contain compounds with addiction liability and are thus Class B medications. Such products are preceded by an asterisk (*).

Analgesics:

Acetaminophen Infants Drops	**Ivax**
Actamin Maximum Strength Liquid (acetaminophen)	**Cypress**
Addaprin Tablet (ibuprofen)	**Dover**
Advil Children's Suspension (ibuprofen)	**Wyeth Consumer**
Aminofen Tablet (acetaminophen)	**Dover**
Aminofen Max Tablet (acetaminophen)	**Dover**
APAP Elixir (acetaminophen)	**Bio-Pharm**
Aspirtab Tablet (aspirin)	**Dover**
Genapap Children Elixir (acetaminophen)	**Ivax**
Genapap Infant's Drops (acetaminophen)	**Ivax**
Motrin Children's Suspension (ibuprofen)	**McNeil Consumer**
Motrin Infants' Suspension (ibuprofen)	**McNeil Consumer**
Silapap Children's Elixir (acetaminophen)	**Silarx**
Silapap Infant's Drops (acetaminophen)	**Silarx**
Tylenol Children's Suspension (acetaminophen)	**McNeil Consumer**
Tylenol Extra Strength Solution (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Drops (acetaminophen)	**McNeil Consumer**
Tylenol Infant's Suspension (acetaminophen)	**McNeil Consumer**

Anti-Asthmatic Agents:

Dilor-G Liquid (guaifenesin/dyphylline)	**Savage**
Elixophyllin-GG liquid (guaifenesin/theophylline)	**Forest**

Anti-Convulsants:

Zarontin Syrup (Ethosuximide)	**Pfizer**

Antiviral Agents:

Epivir Oral Solution (Lamivudine)	**GlaxoSmithKline**

Cough/Cold/Allergy Preparations:

***Accuhist Pediatric Drops** (brompheniramine/pseudoephedrine)	**Propst**
***Alka Seltzer Plus Day Cold** (acetaminophen, dextromethorphan, phenylephrine)	**Bayer**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

*Alka Seltzer Plus Night Cold (acetaminophen, dextromethorphan, phenylephrine, chlorpheniramine, doxylamine)	Bayer
*Allergy Relief Medicine Children's Elixir (diphenhydramine)	Hi-Tech Pharmacal
*Andehist DM Drops (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM Syrup (carbinoxamine/ dextromethorphan)	Cypress
*Andehist DM NR Liquid (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist DM NR Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Cypress
*Andehist NR Syrup (carbinoxamine/pseudoephedrine)	Cypress
*Bayer Alka Seltzer Plus Cold & Cough (acetaminophen, dextromethrophan, phenylephrine, chlorpheniramine)	Bayer
*Benadryl Allergy Solution (diphenhydramine)	Pfizer Consumer
*Biodec DM Drops (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Biodec DM Syrup (carbinoxamine/dextromethorphan/pseudoephedrine)	Bio-Pharm
*Broncotron Liquid (pseudoephedrine)	Seyer Pharmatec
*Buckleys Mixture, (dextromethorphan)	Novartis
Carbatuss Liquid (phenylephrine/guaifenesin)	GM
Cepacol Sore Throat Liquid (benzocaine)	J.B. Williams
*Children's Benadryl Allergy, (diphenhydramine)	Pfizer
*Chlor-Trimeton Allergy Syrup (chlorpheniramine)	Schering Plough
*Codal-DM Syrup (dextromethorphan/phenylephrine/pyrilamine)	Cypress
*Creomulsion Complete Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Creomulsion Cough Syrup (dextromethorphan)	Summit Industries
*Creomulsion For Children Syrup (dextromethorphan)	Summit Industries
*Creomulsion Pediatric Syrup (chlorpheniramine/pseudoephedrine/dextromethorphan)	Summit Industries
*Delsym Cough Suppressant (dextromethorphan)	Cell Tech
*Despec Liquid (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin/ phenylephrine)	International Ethical
*Diabetic Tussin Allergy Relief Liquid (chlorpheniramine)	Healthcare Products
*Diabetic Tussin DM Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Liquid (guaifenesin/dextromethorphan)	Healthcare Products
*Diabetic Tussin DM Maximum Strength Capsule (guaifenesin/dextromethorphan)	Healthcare Products
Diabetic Tussin EX Liquid (guaifenesin)	Healthcare Products
*Diabetic Tussin Nighttime Formula Cold/Flu Relief (dextromethrophan, acetaminophen, diphenhydramine)	Healthcare Products
*Dimetapp Cold & Fever Children's Suspension (ibuprofen/pseudoephedrine)	Wyeth Consumer
*Double-Tussin DM Liquid (guaifenesin/dextromethorphan)	Reese
*Dynatuss Syrup (carbinoxamine/pseudoephedrine/dextromethorphan)	Breckenridge
*Dynatuss EX Syrup (guaifenesin/dextromethorphan/pseudoephedrine)	Breckenridge
*Entex Syrup (phenylephrine/guaifenesin)	Andrx

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Father John's Medicine Plus Drops** (chlorpheniramine/ phenylephrine/ dextromethorphan/ guaifenesin/ammonium chloride)	**Oakhurst**
***Friallergia DM Liquid** (brompheniramine/pseudoephedrine/dextromethorphan)	**R.I.D.**
***Friallergia Liquid** (brompheniramine/pseudoephedrine)	**R.I.D.**
***Gani-Tuss-DM NR Liquid** (guaifenesin/dextromethorphan)	**Cypress**
***Genahist Elixir** (diphenhydramine)	**Ivax**
***Giltuss Pediatric Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Giltuss Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Gil**
***Guaicon DMS Liquid** (guaifenesin/dextromethorphan)	**Textilease Medique**
***Guai-Dex Liquid** (guaifenesin/dextromethorphan)	**Alphagen**
***Guaifed Syrup** (phenylephrine/pseudoephedrine/guaifenesin)	**Muro**
***Hayfebrol Liquid** (chlorpheniramine/pseudoephedrine)	**Scot-Tussin**
***Histex Liquid** (chlorpheniramine/pseudoephedrine)	**TEAMM**
Histex PD Drops (carbinoxamine)	**TEAMM**
Histex PD Liquid (carbinoxamine)	**TEAMM**
***Hydramine Elixir**(diphenhydramine)	**Ivax**
***Hydro-Tussin DM Elixir** (guaifenesin/dextromethorphan)	
***Kita La Tos Liquid** (guaifenesin/dextromethorphan)	**R.I.D.**
***Lodrane Liquid** (brompheniramine/pseudoephedrine)	**ECR**
***Medi-Brom Elixir** (brompheniramine/pseudoephedrine/dextromethorphan)	**Medicine Shoppe**
***Motrin Cold Children's Suspension** (ibuprofen/pseudoephedrine)	**McNeil Consumer**
***Nalex-A Liquid** (chlorpheniramine/phenylephrine)	**Blansett Pharmacal**
***Nalspan Senior DX Liquid** (guaifenesin/dextromethorphan)	**Morton Grove**
***Neotuss-D Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**A.G. Marin**
***Norel DM Liquid** (chlorpheniramine/phenylephrine/ dextromethorphan)	**U.S. Pharmaceutical**
Orgadin Liquid (guaifenesin)	**American Generics**
Organidin NR Liquid (guaifenesin)	**Wallace**
***Palgic-DS Syrup** (carbinoxamine/pseudoephedrine)	**Pamlab**
***Panmist DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	**Pamlab**
***Panmist-S Syrup** (guaifenesin/pseudoephedrine)	**Pamlab**
***PediaCare Cold + Allergy Children's Liquid** (chlorpheniramine/pseudoephedrine)	**Pharmacia**
***PediaCare Cough + Cold Children's Liquid** (chlorpheniramine/ pseudoephedrine/ dextromethorphan)	**Pharmacia**
***PediaCare Nightrest Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Pharmacia**
***Pediahist DM Syrup** (brompheniramine/pseudoephedrine/dextromethorphan/guaifenesin)	**Boca**
***Pedia-Relief Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	**Major**
Pediatex Liquid (carbinoxamine)	**Zyber**
***Pediatex-D Liquid** (carbinoxamine/pseudoephedrine)	**Zyber**
Phanasin Syrup (guaifenesin)	**Pharmakon**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

Phanatuss Syrup (guaifenesin)	**Pharmakon**
***Phena-S Liquid** (chlorpheniramine/phenylephrine)	**GM**
***Poly-Tussin DM Syrup** (chlorpheniramine/phenylephrine/dextromethorphan)	**Poly**
***Primsol Solution**(trimethoprim)	**Medicis**
***Prolex DM Liquid** (guaifenesin/dextromethorphan)	**Blansett Pharmacal**
***Quintex Syrup** (phenylephrine/guaifenesin)	**Qualitest**
***Robitussin Cough & Congestion Liquid** (chlorpheniramine/pseudoephedrine/ dextromethorphan/guaifenesin/acetaminophen)	**Wyeth Consumer**
***Robitussin Cough & Cold Nightime** (chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin Cough & Allergy** (chlorpheniramine, dextromethorphan, phenylephrine	**Wyeth**
***Robitussin Cough & Cold CF** (dextromethorphan, guaifenesin, phenylephrine)	**Wyeth**
***Robtiussin Cold & Flu Nightime** (acetaminophen, chlorpheniramine, dextromethorphan, phenylephrine)	**Wyeth**
***Robitussin DM Liquid** (guaifenesin/dextromethorphan)	**Wyeth Consumer**
***Robitussin PE Syrup** (pseudoephedrine/guaifenesin)	**Wyeth Consumer**
***Robitussin Pediatric Drops** (guaifenesin/dextromethorphan/pseudoephedrine)	**Wyeth Consumer**
***Robitussin Pediatric Night Relief Liquid** (chlorpheniramine/dextromethorphan/ pseudoephedrine)	**Wyeth Consumer**
***Scot-Tussin Allergy Relief Formula Liquid** (diphenhydramine)	**Scot-Tussin**
***Scot-Tussin DM Liquid** (chlorpheniramine/dextromethorphan/guaifenesin)	**Scot-Tussin**
***Scot-Tussin Expectorant Liquid** (guaifenesin)	**Scot-Tussin**
***Scot-Tussin Original Syrup** (phenylephrine)	**Scot-Tussin**
***Scot-Tussin Senior Liquid** (guaifenesin/dextromethorphan)	**Scot-Tussin**
***Sildec Liquid** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec Syrup** (brompheniramine/pseudoephedrine/carbinoxamine)	**Silarx**
***Sildec-DM Drops** (brompheniramine/pseudoephedrine/carbinoxamine/dextromethorphan)	**Silarx**
***Sildec-DM Syrup** (brompheniramine/pseudoephedrine/ carbinoxamine/dextromethorphan)	**Silarx**
Siltussin DAS Liquid (guaifenesin)	**Silarx**
***Siltussin DM Syrup** (guaifenesin/dextromethorphan)	**Silarx**
***Siltussin DM DAS Cough Formula Syrup** (guaifenesin/dextromehtorphan)	**Silarx**
Siltussin SA Syrup (guaifenesin)	**Silarx**
***Simply Cough Liquid** (dextromehtorphan)	**McNeil Consumer**
***Sudatuss DM Syrup** (chlorpheniramine/dextromethorphan/pseudoephedrine)	**Pharmaceutical Generic**
***Tussafed Syrup** (chlorpheniramine/carbinoxamine/ pseudoephedrine/dextromethorphan)	**Everett**
***Tussafed-EX Syrup** (pseudoephedrine/dextromethorphan/guaifenesin)	**Everett**
***Tuss-DM Liquid** (chlorpheniramine/phenylephrine/guaifenesin/dextromethorphan	**Seatrace**
***Tussi-Organidin DM NR Liquid** (guaifenesin/dextromethorphan)	**Wallace**
***Tussi-Pres Liquid** (guaifenesin/dextromethorphan/pseudoephedrine)	**Kramer-Novis**

Alcohol-Free Products

Cough/Cold/Allergy Preparations (cont):

***Tylenol Cold Children's Liquid** (chlorpheniramine/pseudoephedrine/acetaminophen)	McNeil Consumer
***Tylenol Cold Infants' Drops** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Tylenol Flu Children's Suspension** (chlorpheniramine/pseudoephedrine/ dextromethorphan/acetaminophen)	McNeil Consumer
***Tylenol Flu Night Time Max Strength Liquid** (acetaminophen/ doxylamine/ diphenhydramine/pseudoephedrine/dextromethorphan)	McNeil Consumer
***Tylenol Sinus Children's Liquid** (acetaminophen/pseudoephedrine)	McNeil Consumer
***Vicks Dayquil Multi-symptom cold/flu relief** (acetaminophen, dextromethorphan, phenylephrine)	Procter & Gamble
***Vicks 44E Pediatric Liquid** (guaifenesin/dextromethorphan)	Procter & Gamble
***Vicks 44M Pediatric Liquid** (chlorpheniramine/pseudoephedrine/dextromethorphan)	Procter & Gamble
***Z-Cof DM Syrup** (guaifenesin/dextromethorphan/pseudoephedrine)	Zyber

Ear/Nose/Throat Products:

4-Way Saline Moisturizing Mist Spray	Bristol-Myers
Ayr Baby Saline Spray	Ascher, B.F.
Bucalcide Solution (benzocaine)	Seyer Pharmatec
Bucalcide Spray (benzocaine)	Seyer Pharmatec
Bucalsep Solution (benzocaine)	Gil
Bucalsep Spray (benzocaine)	Gil
Cepacol Sore Throat Liquid (benzocaine)	Combe
Gly-oxide Liquid (carbamide peroxide)	GlaxoSmithKline
Consumer Orasept Mouthwash/Gargle Liquid (benzocaine)	Pharmakon Labs
Zilactin Baby Extra Strength Gel (benzocaine)	Zila Consumer

Gastrointestinal Agents

Imogen Liquid (loperamide)	Pharmaceutical
Kaopectate (bismuth subsalicyate)	Ethex

Generic

Kaopectate Suspension (bismuth subsalicylate)	Pharmacia

Consumer

Liqui-Doss Liquid (mineral oil)	Ferndale

Hematinics

Irofol Liquid (iron)	Dayton

Alcohol-Free Products

Miscellaneous

Cytra-2 Solution (sodium citrate salts)	**Cypress**
Cytra-K Solution (sodium citrate salts)	**Cypress**
Emetrol Solution (phosphorated carbohydrate)	**Pharmacia Consumer**

Psychotropics

***Thorazine Syrup** (chlorpromazine)	**GlaxoSmithKline**

Topical Products

Aloe Vesta 2-N-1 Antifungal Ointment (miconazole)	**Convatec**
Fleet Pain Relief Pads (pramoxine)	**Fleet**
Neutrogena Acne Wash Liquid	**Neutrogena**
Neutrogena Antiseptic Liquid	**Neutrogena**
Neutrogena Clear Pore Gel	**Neutrogena**
Neutrogena T/Derm Liquid	**Neutrogena**
Neutrogena Toner Liquid	**Neutrogena**
Podiclens Spray (benzalkonium chloride)	**Woodward**
Sea Breeze Foaming Face Wash Gel	**Clairol**

Vitamins/Minerals/Supplements

Apetigen Elixir (vitamins A & E/multivitamin)	**Pharmaceutical Generic**
Genesupp-500 Liquid (multivitamin)	**Pharmaceutical Generic**
Genetect Plus Liquid (multivitamin/iron)	**Pharmaceutical Generic**
Multi-Delyn w/Iron Liquid (multivitamin/iron)	**Silarx**
Poly-Vi-Sol Drops (multivitamin)	**Mead Johnson**
Poly-Vi-Sol w/Iron Drops (multivitamin/iron)	**Mead Johnson**
Strovite Forte Syrup (multivitamin/iron/folic acid)	**Everett**
Supervite Liquid (multivitamin/B complex/folic acid/multivitamin)	**Seyer Pharmatec**
Suplevit Liquid (multivitamin/iron)	**Gil**
Tri-Vi-Sol Drops (multivitamin)	**Mead Johnson**
Tri-Vi-Sol w/Iron Drops (multivitamin/iron)	**Mead Johnson**
Vitafol Syrup (multivitamin/iron/folic acid/vitamin E/calcium salts)	**Everett**

Incidental Exposure Index

New markers for alcohol use, ethylglucuronide (EtG), ethylsulfate (EtS) and others, have added tremendous value to routine drug testing by their capacity to better document abstinence (allowing for more authoritative advocacy) and sensitively to detect early relapse (allowing for earlier assistance). Since these new markers are highly sensitive, it's important that individuals being tested try to avoid exposure to products containing alcohol that might cause positive tests. This issue is identical to that of avoiding poppy seeds to avoid a positive test for morphine. However, there are many more products containing alcohol. ***Please note that this list is not exhaustive, therefore it is recommended that patients check labels or with manufacturers before using.***

Possible Sources of Incidental Exposure

Foods

Foods can contain trace amounts or large quantities of alcohol. Avoid desserts and other foods cooked with or containing alcoholic beverages such as vodka, sherry, wine, etc. Also avoid foods containing significant amounts of vanilla extract (especially if added to drinks), wine vinegar, soy sauces and other condiments with alcohol content on their labels.

Hygiene Products

Many hygiene related products, such as mouthwashes, contain alcohol and should be avoided. For a comprehensive list of hygiene products that contain alcohol, please read the *Alcohol-Containing Products Table* on the following pages.

Over-the-Counter Medications

Over-the-counter medications, such as cough syrup and tinctures, contain alcohol and should be avoided. Please review the *Over-the-Counter Medications Alcohol Content Table* on the following pages for a more detailed breakdown of OTCs that contain alcohol.

Prescription Medications

Many prescription medications, including asthma inhalers, contain alcohol or ethanol. Always ask your health care provider prior to taking any prescription medications.

Other Sources of Alcohol

Alcohol can be found in many common products including communion wine and "alcohol-free" beer and wine. Recovering patients should also avoid products like hand sanitizers, deodorant sprays, cosmetics and insecticides that contain ethanol vapor and can be inhaled or absorbed through skin application.

Alcohol-Containing Products Table

The following is a list of products and their alcohol contents. Not all of these would actually be likely to be sources of incidental exposure and some would result in very toxic effects if there was much exposure (i.e. Clorox).

Product	*Alcohol %*
ABIN Primer & Sealer	35
Afta After Shave Skin Conditioner 3 OZ.	5-15
Afta Pre-Electric Shave Lotions	50-60
Ajax Antibacterial Dishwashing Liquid 19 OZ.	5-10
Ajax Dishwashing Liquid Antibacterial Hand Soap 38 OZ.	1-5
Aqua Mix Laminate Plus	<9
Aqua Mix Tile Plus More Cleaner-10/31/2000	<9
Ariel Liquid Laundry Detergent	1-5
Armor All Odor Eliminator	3-7
Armor All Odor Eliminator-01/01/2001	1-10
Arrid Total Gel-All Scents	7-12
Avon Black Suede After Shave	60-98
Avon Black Suede Cologne Spray	60-98
Avon Clearskin Targeted Blemish Remover	9.995
Avon Dreamlife Eau de Parfum Spray	60-98
Avon Far Away Sensual Embrace Eau de Parfum Spray	60-98
Avon Ginger Scents Spray Ginger Fresh Body Mist	60-98
Avon Haiku Eau de Parfum Spray	60-98
Avon Imari Eau de Cologne Spray	60-98
Avon Intrigue Cologne Spray	60-98
Avon Lil Hugs Gentle Splash	60-98
Avon Little Black Dress Eau de Parfum Spray	60-98
Avon Memorable Eau de Parfum Spray	60-98
Avon Mesmerize for Men Cologne Spray	60-98
Avon Midnight Frost Fragrance Spray	60-98
Avon Moisture Effective Eye Makeup Remover Lotion	60-98
Avon MUSK FOR BOYS	60-98
Avon NAIL EXPERTS Strong Results	21.74
Avon NATURALS Body Spray, Almond	60-98
Avon NATURALS Body Spray, Cucumber Melon	60-98
Avon NATURALS Body Spray, Gardenia	60-98
Avon NATURALS Body Spray, Lily	60-98
Avon NATURALS Body Spray, Peach	60-98
Avon NATURALS Body Spray, Plumeria	60-98
Avon NATURALS Body Spray, Raspberry	60-98

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Avon NATURALS Body Spray, Sea	60-98
Avon NATURALS Body Spray, Vanilla	60-98
Avon Night Evening Magic Cologne Spray	60-98
Avon Passion Dance for Men	60-98
Avon Passion Dance for Women	60-98
Avon Perceive Eau de Parfum Spray for Women	60-98
Avon Perceive For Men Cologne Spray	60-98
Avon Pink Suede Eau de Toilette Spray	60-98
Avon Planet Spa White Tea Energizing Face and Body Mist	60-98
Avon Prospect Eau de Toilette Spray	60-98
Avon Radiant Moments Body Spray	60-98
Avon RARE GOLD Eau de Parfum Spray	60-98
Avon RARE PEARLS Eau de Parfum Spray	60-98
Avon Simply Radiant Shimmering Body Spray	60-98
Avon Vintage Cologne Spray	60-98
Avon WILD COUNTRY After Shave	60-98
Avon WILD COUNTRY Cologne Spray	60-98
Avon Wild Country Outback After Shave Lotion	60-98
Avon Wild Country Outback Eau De Toilette Spray	60-98
Bath & Body Instant Anti-Bacterial Hand Gel-Freesia	60
Bay Rum After Shave Balm	30
Bold Liquid Laundry Detergent	1-5
Bravo Platinum Series Metered Air Freshener	15-25
Bulls Eye Clear Shellac	55
Cascade Crystal Clear Plus Shine Shield Rinse Agent 8.45 fl oz	3-7
Cheer Liquid Laundry Detergent	1-5
Clorox Dual Action Toilet Bowl Cleaner 1 Pt. 9 Fl. Oz. (Chambered Bottle)	1-5
Clorox Spring Mist Disinfecting Spray-Floral Fresh 18 Oz. (aerosol)	60-80
Cutter All Family Insect Repellent 2 Aerosol	35
Cutter All Family Insect Repellent Mosquito Repellent Pump Spray	39
Cutter Insect Repellent	17
Cutter Skinsations Insect Repellent 1, Aloe & Vitamin E, Clean Fresh Scent	50
Cutter Unscented Backwoods Insect Repellent, Water-Resistant Sport Formula, Aerosol	35
Cutter Unscented Backwoods Mosquito Wipes	29
Cutter Unscented Insect Repellent	37
Cutter Unscented Outdoorsman Insect Repellent II Pump Spray	44
Cutter Unscented Outdoorsman Insect Repellent, Water-Resistant Sport Formula, Aerosol	20

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
DAP Easy Bond Adhesive	1.0-5.0
Dawn Manual Pot and Pan Detergent	5-10
Dawn Manual Pot and Pan Detergent (Professional Line)	5-10
Deep Woods OFF!	50-60
Deep Woods Off! Pump Spray	30-40
Dermassage Dishwashing Hand Liquid - Regular	1-5
Downy Advanced w/Wrinkle Control Fabric Softener (Clean Breeze, Mountain Spring)	1-5
Downy Enhancer	1-5
Downy Enhancer (Invigorating Burst and Calming Mist)	1-5
Downy Premium Care	1-5
Dreft Liquid Laundry Detergent	1-5
Easy Off Heat Activated Microwave Wipes	5-10
Era Liquid Laundry Detergent	1-5
Fab Color Plus Ultra Power	1-5
Farnam Cologne & Deodorant for Pets	20
Febreze Air Effects 9.7 oz Blossoms and Breeze	3-7
Febreze Air Effects 9.7 oz Citrus and Light	3-7
Febreze Air Effects 9.7 oz Spring and Renewal	3-7
Febreze Concentrated Fabric Refresher	12-17
Febreze Fabric Refresher	1-5
Fire Up II Firestarter	<85
Gain Liquid Laundry Detergent	1-5
Giant Auto Dish Detergent 75 OZ BOX	1-5
Giant Pure Power Auto Dish Detergent Lemon 45 OZ BOX	1-5
Glade Fragrant Mist Country Garden	7-13
Glass Mates	4.0-6.0
Glass Mates-05/16/2000	4.0-6.0
HOUSE SAVER Pet Stain & Odor Remover	20
Invisible Shield Surface Protectant-04/11/2002	78
Ivory Snow Liquid Laundry Detergent	1-5
KimCare Instant Hand Sanitizer	60
Lady Speed Stick Clear Antiperspirant Deodorant Gel	15-20
Listerine Antiseptic Mouthwash	26.9
Listerine Cool Mint Antiseptic Mouthwash	23
Listerine Fresh Burst Antiseptic Mouthwash	23
Listermint Mouthwash	<10
Loctite Crafter's All Purpose Adhesive	3-5

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Loctite Fabric Glue	3-5
Loctite Outdoor Fixture Adhesive	1-5
LOreal Pumping Curls for Curly Hair	41
Lysol Brand Antibacterial Hand Gel	63
Lysol Brand Disinfectant Spray, Antibacterial, Original Scent	79.0
Lysol Brand II Disinfectant Plus Fabric Refresher 12 oz	85
Lysol Brand II Disinfectant Spray-Country Scent (aerosol)	79
Lysol Brand Sanitizing Wipes-Citrus Scent	8-10
Lysol Brand Sanitizing Wipes-Spring Waterfall 52 oz	8-10
Lysol Brand Scrubbing Wipes-Orange Breeze Scent	8-12
Martin Weber Blue Label Fixatif Spray	60-70
Martin Weber Cleaning Solution	31
Mr Muscle Pot & Pan Detergent	3-7
Nair Hair Remover Kit, Cold Wax Strips Pretreatment Towelette	5-20
New-Skin Liquid Bandage	5
Nilodor Air Freshener-Floral	0.5-3.5
Nilodor Carpet Care Deodorizing Spot/Stain Remover	2-6
Nilodor Deodorizing Carpet Extractor	2-6
Nilodor Odor Neutralizer	0.5-3.5
Nilotex Carpet Care	2-6
Off Skintastic Insect Repellent for Kids	>90
Off! Deep Woods for Sportsmen Insect Repellent IV, Aerosol	50-60
Off! Deep Woods Insect Repellent V Spray, Unscented	50-60
Off! Skintastic IV	90-95
Old English Furniture Wipes	4-8
Oust Air Sanitizer, Outdoor Scent	60-70
Oust Bathroom Citrus Scent Fan .40 oz.	40-60
Oust Bathroom Outdoor Scent Fan	40-60
Palmolive Original Hand Dishwashing Liquid	4.3
Paul Mitchell Freeze & Shine Super Spray	>60
Paul Mitchell Freeze & Shine Super Spray (New)	<60
Paul Mitchell Soft Sculpting Spray Gel	<20
Pine Power Disinfectant Cleaner	<5.0
Purell Instant Hand Sanitizer	62
Purell Instant Hand Sanitizer Dry Hands Formula	62
Purell Instant Hand Sanitizer Packets	62
Purell Instant Hand Sanitizer with Aloe, Moisturizers & Vitamin E	62
Purell Instant Hand Sanitizer, Original	62

Incidental Exposure Index

Alcohol-Containing Products Table

Product	*Alcohol %*
Purell Kids Own Berry Blast	62
Radio Shack 951 Low Residue Soldering Paste Flux	73
Radio Shack Cleaner/Degreaser	27
Radio Shack Professional Tape Head Cleaner	15-20
Rain X Marine Windshield Treatment	70-95
Rain X The Invisible Windshield Wiper	86
Rain-X Anti-Fog	70-99
Rain-X Windshield Wax	70-95
Repel Hunters' Insect Repellent with Earth Scent, 55 Percent DEET	<45
Repel Insect Repellent Family Formula Spray Pump, 23 Percent DEET	44
Repel Insect Repellent Scented Family Formula Aerosol, 23 Percent DEET	48.3
Repel Insect Repellent Sportsmen Formula Spray Pump, 25 Percent DEET	55
Repel Insect Repellent Sportsmen Max Formula, 40 Percent DEET	43.7
Repel Lemon Eucalyptus Insect Repellent Lotion	<10
Repel Lemon Eucalyptus Insect Repellent Spray Lotion	<10
Soft Soap Hand Sanitizer - Gel	60-65
Spic and Span 10X Concentrate Disinfecting All Purpose Spray	12-25
Spic and Span Floor and Multi Surface Cleaner	0-5
Spray N Wash Laundry Stain Remover	2-3
Static Guard	70-72
Survivor Lemon Eucalyptus Insect Repellent Lotion	<10
TEN O SIX Medicated Deep Pore Cleanser	<15
Time Mist Air Freshener W/Odor Counteractant	15-25
Ultra Downy Liquid Fabric Softener	1-5
Valspar One & Only Interior/Exterior Multi Purpose Flat Black Finish	5-10
Valspar One & Only Multi Purpose Gloss Enamel, Almond	5-10
Valspar One & Only Multi Purpose Gray Metal Primer	5-10
Viadent Advanced Care Rinse	5-10
Wet Ones Antibacterial Moist Towelettes, Citrus	9.6
Wet Ones Antibacterial Moist Towelettes, Travel Pack, Citrus	9.6
Wet Ones Antibacterial Portable Washcloths, Ultra	0-9.6
Wet Ones Kids Antibacterial Wipes, Wild Watermelon & Ballistic Berry	0-9.6
Wet Ones Moist Towelettes with Aloe, Travel Pac	0-10.5
Wet Ones Moist Towelettes with Vitamin E & Aloe	0-10.5
Wet Ones Portable Washcloths with Vitamin E & Aloe, Ultra	0-10.5
Wet Ones Ultra Portable Antibacterial Wash Cloths	9.6
Wet Ones, Antibacterial Moist Towelettes, Thick Cloths	9.6
Zep Tile and Terrazzo Cleaner	5-15

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Ambenyl	cough suppressant	Forest	5
Ambenyl-D	expectorant, nasal decongestant, cough suppressant	Forest	9.5
Anesol	oral antiseptic, anesthetic	Whitehall	70
AsbronG Elixir	anti-asthmatic	Sandoz	15
Bayer children's Cough Syrup	cough suppressant, nasal decongestant	Glenbrook	5
Benadryl Decongestant Elixir	antihistamine	Parke-Davis	5
Benadryl Elixir	antihistamine	Parke-Davis	14
Benylin Cough Syrup	cough suppressant	Parke-Davis	5
Benylin DM	cough suppressant	Parke-Davis	5
Bronkolixir	bronchodilator, decongestant	Winthrop	19
Cepacol/Cepacol Mint	mouthwash, gargle	Lakeside	14.5
Ce-Vi-Sol	vitamin C drops (infant)	Mead-Johnson	5
Cheracol D	cough suppressant, decongestant	Upjohn	4.75
Cheracol Plus	cough suppressant, decongestant	Upjohn	8
Chlor-Trimeton Allergy Syrup	antihistamine	Schering	7
Choedyl Elixir	bronchodilator	Parke-Davis	20
Colace Syrup	laxative	Mead-Johnson	1
Colgate Mouthwash	mouthwash/gargle	Colgate-Palmolive	15.3
CONTAC Nighttime	antihistamine, analgesic, cough suppressant, decongestant	SmithKline	25
Dilaudid Cough Syrup	cough suppressant, analgesic	Knoll	5
Dimetane Elixir	antihistamine	A. H. Robins	3
Dimetane Decongestant Elixir	antihistamine, decongestant	A. H. Robins	2.3
Dimetapp Elixir	decongestant, antihistamine	A. H. Robins	2.3
Diural Oral Suspension	diuretic, antihypertensive	Merck Sharp & Dohme	0.5
Donnatal Elixir	anti-spasmodic	A. H. Robins	23
Elixophyllin-Kl Elixir	anti-asthmatic	Forest	10
Feosol Elixir	iron supplement	SmithKline	5
Fergon Elixir	iron supplement	Winthrop	7
Geriplex-FS	vitamins (geriatric)	Parke-Davis	18
Geritol Liquid	vitamins	Beecham	12
Geritonic Liquid	vitamins	Geriatric	20
Gevrabon	vitamins	Lederle	18
Hycotuss	expectorant	DuPont	10
I.L.XB12 Elixir	iron supplement	Kenwood	8
Iberet Liquid	vitamins	Abbott	1

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Imodium A-D	anti-diarrheal	McNeil	5.25
Incremin	vitamins	Lederle	0.75
Indocin Oral Suspension	analgesic	Merck Sharp & Dohme	1
Kaochlor S-F	potassium supplement	Adria	5
Kaon-CL 20%	potassium/chloride supplement	Adria	5
Kaon Elixir	potassium supplement	Adria	5
Kay Ciel Oral Solution	potassium supplement	Forest	4
Klorvess 10% Liquid	potassium/chloride supplement	Sandoz	0.75
Lanoxin Elixir Pediatric	cardiac medication	Burrougfhs Wellcome	10
Lasix Oral Solution	diuretic	Hoechst-roussel	11.5
Listerine Antiseptic	mouthwash/gargle	Warner-Lambert	26.9
Lomotil Liquid	anti-diarrheal	G. D. Searle & Co.	15
Lufyllin Elixir	bronchodilator	Wallace	20
Marax-DF Syrup	bronchodilator	Roerig	5
May-Vita Elixir	vitamins	Mayrand, Inc.	13
Mediatric Liquid	estrogen replacement	Wyeth-Ayerst	15
Mellaril Oral Solution	antipsychotic	Sandoz	3-4.2
Mestinon Syrup	treatment of myasthenia ravis	Roche	5
Naldecon DX Pediatric Drops	decongestant	Bristol	0.6
Nicotinex	niacin supplement	Fleming & Co.	14
Niferex Elixir	iron supplement	Center Labs	10
Novahistine Elixir	antihistamine, decongestant	Lakeside	5
Novahistine Expectorant	cough suppressant, decongestant, expectorant	Lakeside	7.5
Nucofed Expectorant	cough suppressant, decongestant, expectorant	Beecham	12.5
Nucofed Pediaric Expectorant	cough suppressant, expectorant, decongestant	Beecham	6
Nu-Iron Elixir	iron supplements	Mayrand, Inc.	10
Nystex Oral Suspension	antifungal antibiotic	Savage	1
Organidin Elixir	expectorant	Wallace	21.75
PBZ Elixir	antihistamine	Geigy	12
Pamelor Oral Solution	anti-depressant	Sandoz	3-5
Peri Colace Syrup	laxative	Mead-Johnson	10
Permitil Oral Concentrate	anti-psychotic	Schering	1
Phenergan Syrup Plain	antihistamine	Wyeth-Ayerst	7
Phenergan Syrup Fortis	antihistamine	Wyeth-Ayerst	1.5
Phenobarbital Elixir	sedative	Rosane	13.5
Polaramine Syrup	antihistamine	Schering	6

Incidental Exposure Index

Over-the-Counter Medications Alcohol Content Table

Item	*Use*	*Manufacturer*	*Alcohol %*
Poly-Histine Elixir	cough suppressant	Bock	4
Prolixin Elixir	anti-psychotic	Princeton	14
Quelidrine Syrup	cough suppressant	Abbott	2
Robitussin	expectorant	A. H. Robins	3.5
Robitussin A-C	cough suppressant, expectorant	A. H. Robins	3.5
Robitussin CF	cough suppressant, decongestant, expectorant	A.H. Robins	3.5
Robitussin DAC	expectorant, decongestant, cough suppressant	A. H. Robins	1.9
Robitussin Night Relief	analgesic, cough suppressant, decongestant	A. H. Robbins	25
Robitussin PE	decongestant, expectorant	A. H. Robbins	1.4
Sandimmune	immunosuppressant	Sandoz	12.5
Scot-Tussin Sugar-Free Expectorant	expectorant	Scott-Tussin	3.5
Sominex Liquid	sleep aid	Beecham	10
Sudafed Cough Syrup	decongestant	Burroughs Wellcome	2.4
Tacaryl Syrup	antihistamine	Westwood	7.37
Tagamet Liquid	ulcer medication	Smith Kline & French	2.8
Tavist Syrup	antihistamine	Sandoz	5.5
Theo-Organidin Elixir	bronchodilator, expectorant	Wallace	15
Triaminic Expectorant	expectorant, decongestant	Sandoz	5.5
Tussar-2	cough suppressant	Rorer	5
Tussar SF	cough suppressant	Rorer	12
Tussend	cough suppressant	Lakeside	5
Tussend Expectorant	cough suppressant, decongestant, expectorant	Lakeside	12.5
Tylenol Adult Liquid Pain Reliever	analgesic	McNeil	7
Tylenol Cold Medication Liquid	analgesic, decongestant, cough suppressant, antihistamine	McNeil	7
Tylenol with Codeine Elixir	analgesic	McNeil	7
Vicks Daycare Liquid	decongestant, analgesic, expectorant, cough suppressant	Richardson-Vicks	10
Vicks Formula 44	cough suppressant, antihistamine	Richardson-Vicks	10
Vicks Formula 44D	cough suppressant, decongestant	Richardson-Vicks	10
Vicks Formula 44M	cough suppressant, decongestant, analgesic	Richardson-Vicks	20
Vicks Nyquil	decongestant, cough suppressant, antihistamine, analgesic	Richardson-Vicks	25

Products Containing Alcohol

Please note: Some prescription nasal sprays used for allergic rhinitis and some other forms of nasal/sinus congestion contain alcohol. Alcohol-containing nasal sprays that should be avoided by recovering persons, especially those taking Antabuse, include Flonase and Nasonex nasal sprays. The majority of mouthwashes contain alcohol also. These should all be avoided.

5% Alcohol (10-Proof)

Diphenhydramine Elixir
Benylin Cough Syrup
Cheracol-D Cough Syrup (guaifenesin/dextromethorphan)
Dihstine DH Elixir (chlorpheniramine/pseudoephedrine/codeine)
Dilaudid Cough Syrup (hydromorphone)
Dramamine Liquid (dimenhydrinate)
Feosol (iron) Elixir
Imodium A-D (loperamide)
Kaon Liquid (potassium)
Kay Ciel Liquid (potassium)
Guiatuss AC Syrup (guaifenesin/codeine)
Phenergan VC Syrup (promethazine/phenylephrine)
Tussend Syrup (guaifenesin/chlorpheniramine/pseudoephedrine/hydrocodone)
Tylenol Extra Strength Liquid
Tylenol with Codeine Elixir
Vicks 44 D (dextromethorphan/pseudoephedrine)
Vicks 44 E (guaifenesin/dextromethorphan)

10% Alcohol (20-Proof)

Excedrin PM Liquid (acetaminophen/diphenhydramine)
Geritol Tonic Liquid (multivitamin)
Hycotuss Expectorant Syrup (hydrocodone/guaifenesin)
Niferex Elixir (iron)
Nucofed Expectorant Syrup (guaifenesin/pseudoephedrine/codeine)
Nu-Iron Elixir (iron)
Vicks Nyquil (doxylamine/pseudoephedrine/dextromethorphan/acetaminophen)
Vicks Formula 44M (chlorpheniramine/pseudoephedrine/dextromethorphan/acetaminophen)

15% Alcohol (30-Proof)

Cepacol Mouthwash
Gerivite Elixir (multivitamin)
Lomotil Liquid (diphenoxylate/atropine)

20% Alcohol (40-Proof)

Gevrabon Liquid (vitamins)
Listerine Mouthwash (flavored)
Lufyllin Elixir (theophylline)
Theophylline Elixir

25% Alcohol (50-Proof)

Listerine Mouthwash (regular)
N'ice Throat Spray

This document was created by Talbott Recovery Campus. For more information, please visit www.talbottcampus.com.

Talbott Recovery Campus
5448 Yorktowne Drive
Atlanta, GA 30349

FSSolutions
Quality Service Since 1989

100 Highpoint Drive, Suite 102
Chalfont, PA 18914
www.firstsourcesolutions.com

T 800. 732. 3784
F 215. 396. 5609
E info@fssolutions.com

Drug	% Alcohol
Actol Expectorant Syrup	12.5
Alertonic	0.45
Alurate Elixir	20.0
Ambenyl Expectorant	5.0
Anahist	0.5
Aromatic Elixir	22.0
Anaspaz-Pb Liquid	15.0
Asbron Elixir	15.0
Atarax Syrup	0.5
Bactrim Suspension	0.3
Tr. Belladonna	67.0
Benadryl Elixir	14.0
Bentyl-Pb Syrup	19.0
Benylin Expectorant	5.0
Brondecon Elixir	20.0
Bronkelixir	19.0
Butibel Elixir	7.0
Calcidrine Syrup	6.0
Cas Evac	18.0
Aromatic Cascara Sagroda	18.0
Carbrital Elixir	18.0
Cerose & Cerose DM Expectorant	2.5
Cheracol & Cheracol D	3.0
Choledyl Elixir	20.0
Chlor-Trimeton Syrup	7.0
Cologel Liquid	5.0
Citra Forte Syrup	2.0
Coldene Cough Syrup	15.0
Conar Expectorant	5.0
Coryban D	7.5
Cosanyl DM & Cosanyl Syrup	6.0
Copavin Cmpd Elixir	7.0
Darvon-N Suspension	1.0
Decadron Elixir	5.0
Dexedrine Elixir	10.0
Demazin Syrup	7.5
Dilaudid Cough Syrup	5.0
Elixir Dimetane	3.0
Dimetane Expectorant	3.5
Dimetane Expectorant-DC	3.5
Doxinate Liquid	5.0
Dimetapp Elixir	2.3
Dimacol Liquid	4.75
Donnatal Elixir	23.0
Donnagel Suspenslon	3.8
Donnagel PG Suspenslon	5.0
Dramamine Liquid	5.0

Drug	% Alcohol
Feosol Elixir	5.0
Fer-ln-Sol Syrup	5.0
Theoelixir (Elixir Theophylline)	20.0
Elixophy	20.0
Elixophylline-KL	10.0
Ephedrine Sulfate Syrup USP	3.0
Ephedrine Sulfate Syrup - Note USP	12.0
Fer-ln-Sol Drops	0.2
Geriplex-FS	18.0
Gevabon Liquid	18.0
Kaon Elixir	5.0
Kaochlor	3.8
Iberet Liquid	1.0
Isuprel Comp. Elixir	19.0
Syrup Ipecac	2.0
Hydryllin Comp.	5.0
Hycotuss Expectorant & Syrup	10.0
Kay-Ciel Elixir	4.0
Lanoxin Elixir Pediatric	10.0
Liquid Lomotil	15.0
Luffyllin-GG Elixir	17.0
Marax Syrup	5.0
Mediatric Liquid	15.0
Modane Liquld	5.0
Mellaril Concentrate	3.0
Mesopin Elixir	12.5
Minocin Syrup	5.0
Nembutal Elixir	18.0
Novahistine DH	5.0
Nicol Elixir	10.0
Novahistine Expectorant	5.0
Novahistine Elixir	5.0
Novahistine DMX	10.0
Nico-Metrazol Elixir	15.0
Nyquil Cough Syrup	25.0
Mol Iron Liquid	4.75
Organidin Elixir	23.75
Ornacol Liquid	8.0
Tincture Paregoric	45.0
Parapectolin	0.69
Parelexir	18.0
Periactin Syrup	5.0
Pertussin 8 Hour Syrup	9.5
Phenergan Expectorant Plain	7.0
Phenobarbital Elixir	14.0
Phenergan Expect. w/Codeine	7.0

Drug	% Alcohol
Phenergan Expectorant VC Plain	7.0
Phenergan Expectorant VC w/Codeine	7.0
Phenergan Expectorant Pediatric	7.0
Phenergan Syrup Fortis (25 mg)	1.5
Polaramine Expectorant	7.2
P.B.Z. Expectorant with Ephedrine	6.0
Propadrine Elixir HCI	16.0
P.B.Z. Expectorant w/Codeine & Ephedrine	6.0
Quibron Elixir	15.0
Robitussin Syrup	3.5
Robitussin AC Syrup	3.5
Robitussin PE	1.4
Robitussin DM and Robitussin CF	1.4
Rondec DM Syrup and Drops	0.6
Roniacol Elixir	8.6
Serpasil Elixir	12.0
Tedral Elixir	15.0
Temaril Syrup	5.7
Terpin Hydrate Elixir	42.0
Terpin Hydrate Elixir w/Codeine	42.0
Theo Organidin Elixir	15.0
Triaminic Expectorant	5.0
Triaminic Expectorant DH	5.0
Tussend Liquid	5.0
Tussar-2 Syrup	5.0
Tussi-Organidin Expectorant	15.0
Tussar SF Syrup	12.0
Tuss-Ornade Syrup	7.5
Tylenol Elixir	7.0
Tylenol with Codeine Elixir	7.0
Tylenol Drops	7.0
Ulo-Syrup	6.65
Valadol Llquid	9.0
Valpin-PB Elixir & Valprin	5.3
Vita Metrazol Elixir	15.0
Vlcks Formula 44	10.0
Potassium Chloride Sol. (Standard)	10.0

(a no-alcohol solution can be requested)

100 Highpoint Drive, Suite 102
Chalfont, PA 18914
www.firstsourcesolutions.com
T 800. 732. 3784
F 215. 396. 5609
E info@fssolutions.com

NOTE:

1. Mouthwashes - Scope, Listerine, Cepacol, Colgate 100, Micrin, all contain approximately 15 - 25% alcohol.

2. All elixirs contain some alcohol.

3. The following anti-tussives do *not* contain alcohol:

    * Hycodan Syrup

    * Hycomine Syrup Triaminicol Syrup

    * Tussionex Suspension Orthoxicol Syrup Actifed C Expectorant Omnituss Ipsatol Syrup

4. Other non-alcohol liquids:

Chloraseptic mouthwash/gargle Liquiprin (acetaminophen) Dilantin Suspension Alupent Syrup

    * Noctec Syrup

    * Vistaril Suspension Antacids Kapoectate and Parget, etc. Sudafed Syrup

    * Quadrinal Suspension Actifed Syrup Triaminic Syrup Naldecon Syrup Nydrazid Syrup

*Ingestive medications may contain other addictive substances which may be considered.