RECOVERY TECHNOLOGY LLC

OFFICE
1200 N. West Avenue
Suite 400
Jackson, MI 49202

PHONE
517-780-3336

FAX
517-796-4561

www.recoverytechnology.org

Date:

Re:
DOB:

Dear Dr.

We currently serve this mutual patient who is receiving psychotropic medications from our agency. I am reaching out to you to inquire if you would be willing to prescribe the following medications as the patient is stable and no longer needs the intensity of the services we provide.

The current prescribed medications are as follows:

_____

_____

_____

_____

Please confirm that you are willing to take over prescribing these medications by checking the box below, signing, then faxing this letter back to our office at **517-796-4561**. Upon receipt of your agreement, we will coordinate with the patient and discharge the patient to your care. Please note that we can be available for consult if needed.

☐ Yes, I agree to take over the prescribing of psychotropic medications for this patient.

☐ No, I will not agree to prescribe these medications for this patient.

Physician Signature: _____

Thank you for your thoughtful consideration of this request.

Sincerely,

Case Manager
517-780-3336
Fax: 517-796-4561