Mission Statement

"Recovery Ventures is a nonprofit organization that offers long-term, residential treatment and aftercare services to individuals suffering from substance-use disorders in a safe and healthy environment that promotes self sufficiency, emotional growth, personal accountability and personal values enhancement."

Founded
March 25, 2002

Recovery Ventures Corporation is a 501(c)3 Charitable Organization

North Carolina Charitable Solicitation License Number SL003149

Contributions and personal donations are tax deductible under US Internal Revenue Service Code.

Licensed By the State Of North Carolina Department Of Health And Human Services
License Number: MHL-059-035

Post Office Box 549
Black Mountain, NC 28711
Phone: (828) 686-0354
Fax: (828) 686-0359

Program Overview

Recovery Ventures is a twenty-four month, residential Therapeutic Community for individuals suffering from substance-use disorders. Primary care is followed by a transitional and supportive housing environment and aftercare services.

Components:

1. **Therapeutic**
   - Milieu therapy
   - Associates actively participate in program activities
   - Group counseling, individual counseling, and psycho-educational groups
   - Structured environment and daily routines, educational seminars, peer counseling.

2. **Job Skills Training/Interdependent Responsibility** –
   - Associates participate in both in-house and outside job placements immediately upon entry
   - Associates learn to be responsible in a number of areas that lead to manageability of their own lives

3. **Education**
   - Associates must be working toward individualized, mutually agreed upon educational goals
   - Associates will work to obtain GED, and are eligible to attend a local community college after moving into the Enrichment phase of their program

4. **Spirituality**
   - Associates develop spiritual connections with each other and/or their Higher Power.

5. **Aftercare**
   - Required continuum of care
   - Associates step-down to transitional housing before graduation;
   - Participants must serve as mentors to younger residents during this time.

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DIRECTORY INFORMATION

MAIN OFFICE

David F. Martin, Executive Director
Steve Sorrells, MA, NCC, LCAS, Clinical Director

Recovery Ventures Corporation
PO Box 549
Black Mountain, NC 28711
Voice: 828-686-0354
Fax: 828-686-0359

General Correspondence E-mail- RVCWNC@aol.com
Admissions E-mail – rvcintakes@aol.com
Website www.recoveryventurescorp.org

FACILITY LOCATIONS

Men's Facility
Old Fort, NC

Women's Facilities
Swannanoa, NC

Transitional Housing Facilities
Old Fort, NC
Asheville, NC
Ridgecrest, NC
Swannanoa, NC

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Recovery Ventures seeks to integrate associates into a healthy, substance-free environment that provides clinical services, personal responsibilities and accountability, positive role models, emotional growth, community service involvement, and aftercare services. This approach is aimed at restructuring one's life and developing a positive, interdependent lifestyle.

Recovery is not easy! Most program staff are in "active recovery" from addiction. The staff 's personal experience in recovery is combined with professional training to help assist associate's in rebuilding their lives and living in recovery. We are strongly committed to the belief that *"Helping others is a key to recovery."*

Recovery Ventures is not easy! We do not want you to think that you are going on a vacation, to a weekend at the beach or mountains. Nothing in our paperwork should give you the impression that this is a rest and relaxation retreat. Recovery Ventures is a highly structured, supervised and more often than not, a very demanding program. No one can give anyone their recovery. It must be earned much in the same way that Recovery Ventures survives and remains in operation, by earning what we receive.

Each facility is self-supporting! It is the responsibility of every associate in the program to contribute to the generation of operational income. This income provides for each current associate and ensures that others seeking recovery will have a program to participate in. In the "real world" each day involves getting out of bed, fixing meals, going to work, keeping the house clean, taking care of the younger ones (new associates), washing dishes, cutting the grass, meeting with friends, paying the bills, doing paperwork, recreation and leisure activities and advancing our knowledge and emotional growth. The "Recovery Ventures world" works very much the same way with each individual playing his/her part to make it work.

Responsibility, proper conduct, ethical behavior, accountability and safety in the community are all primary aspects of the Recovery Ventures program. We are comprised of a very diverse population, being of all races, genders, beliefs, origins, economic and social statuses. Recovery Ventures, like addiction, discriminates against no one. We have established rules and regulations that must be strictly adhered to by all associates at all times. You will have access to our established policies and procedures, along with definitions of unacceptable behavior, when you arrive at our facility. Violations of established policies and procedures will result in appropriate action being taken and/or termination from the program. It is not acceptable for any participant in the Recovery Ventures program to feel threatened, intimidated, coerced or manipulated by any other associate or external party having any association with Recovery Ventures Corporation. All violations of established policies and procedures, threats, violence or any questionable activity are to be reported immediately to staff personnel for appropriate action.

Substance abuse treatment costs money, and unfortunately, the majority of us who need treatment have little or no money, no insurance, and in many cases, no one that is willing to help bear the financial burdens of long term treatment. As stated previously, you earn what you get at Recovery Ventures. Participation in *Recovery Ventures* is voluntary to anyone requesting participation in our program. Recovery Ventures is a self-supporting, non-profit organization. We also request corporate donations of various items that are needed by the associates in our program. These items include clothing, hygiene products, medical supplies and services and materials needed to repair and improve our facilities. The majority of our daily operational and administrative expenses of telephone service, electricity, water & sewer services, gasoline, etc. are paid for through the work we perform for contract employers and our independently operated business ventures.

Rebuilding relationships with children and family is a very important part of recovery. Many of our most significant relationships were damaged while in active addiction. Family issues can improve with clinical guidance, time, patience, and proof that those in recovery are making progress toward changing their negative behaviors. Our program takes a proactive role in re-establishing relationships through individual and group therapy sessions. , in which there is open and honest communication with loved ones and scheduled events that welcome parents and/or children to visit our facilities and observe our activities. Married associates will be eligible to attend relationship group upon progression to the leadership phase. The objective of this group is to assist associates in a structured, rebuilding of the relationship. Correspondence, phone calls, and visitation are all privileges that are earned through the participation in the group and subject to staff approval. BE PATIENT! Non-married program associates are eligible to participate in relationship group upon entering the Enrichment phase. Communications with loved ones, by telephone and/or mail is an earned privilege that may be lost due to violations of program policies and procedures. You must value and protect the privileges you have worked so hard to earn.

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TRANSITION PHASE
45-60 days

- **Emphasis on becoming familiar with new surroundings and developing relationships with other program associates**
- **Education on program rules, policies, and procedures**
- **Comprehensive clinical assessment is completed by program staff**
- **An initial treatment plan is established**

ACCLIMATION PHASE
Up to 6 months

- **Opportunity to earn privileges**
- **Begin correspondence with family through letters and phone calls (phone calls are limited)**
- **Assignment of household responsibilities based on progress in the program**
- **Expected to have a working knowledge of program rules, policies, and procedures**
- **Enrollment in Anger Management and Grief and Loss curriculums**
- **Treatment plans are reviewed and updated every 90 days**
- **Encouraged to assist new program associates in developing a working knowledge of the program**

LEADERSHIP PHASE
6-12 months

- **Begin accepting more responsibility for the proper guidance and development of newer associates (peer leader)**
- **Eligible to participate in the Family Education Program**
- **Eligible to participate in off-campus, weekend visits with immediate family (not overnight)**
- **Developing a better understanding of personal issues and cultivating the skills necessary to work on these issues**

ENRICHMENT PHASE
12-18 months

- **Participation in Aftercare, Relapse Prevention, and Life Skills curriculums**
- **Emphasis on more personal responsibility (developing community support, budgeting, etc.)**
- **Eligible to participate in home visits (weekend visit, fellow associate accompanies as a strength)**
- **Continued participation community peer leaders (facility house managers, group assistance, enforcing accountability, etc.)**
- **Cultivate individual, career, and educational goals with the assistance of program staff**

INTERNSHIP PHASE (AFTERCARE)
18-24 months

- **Emphasis on establishing community-based recovery support**
- **Securing gainful employment**
- **Move into transitional housing**
- **Establishing a bank account and personal budget**
- **Begin to pay rent for program housing**
- **Continued participation in Aftercare, Relapse Prevention, and Life Skills curriculums**
- **Expected to maintain connection with "core" of the program through mentoring of program associates and participation in on-site groups**

*Progression through program phases is based upon adhering to program rules, completion of phase requirements, and meeting treatment plan objectives. Failure to meet any of these requirements can result in loss of privileges and extensions of current phase.

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Application Procedures and Admission Process

The **"PRIMARY QUALIFICATION"** for acceptance is the sincere desire to remain in recovery and to make a lifelong commitment to help others recover.

Exclusionary Criteria:

1. Applicants with a prior criminal history including convictions for **arson** or **sexual misconduct,**
2. Applicants with long histories of **violence**,
3. Applicants who are on **intensive probation**,
4. Applicants who have **exhibited exaggerated psychiatric symptoms** or **suicidal/homicidal ideations** within the past 90 days.
5. Applicants who require **psychotropic medications** will be considered on a case by case basis.

TO APPLY:

- ✓ Admissions office hours are Monday – Friday: 8 AM – 5 PM
- ✓ Complete all application paperwork
- ✓ Submit an autobiography
  - Minimum 3-6 pages
  - Give details of your life from as far back as you can remember, up to and including your personal decision to complete our application
- ✓ Obtain current TB and HIV test (within the last 6 months)
- ✓ Obtain a criminal record from any state that you have ever resided in (if you need assistance discuss this with our admissions coordinator)
- ✓ Complete a telephone interview with an admissions coordinator

UPON ACCEPTANCE:

- Transportation arrangements need to be discussed with admissions coordinator. Recovery Ventures **does not** provide transportation.\
- Upon acceptance an entry date will be scheduled by the admissions coordinator. Failure to report on your scheduled entry date can result in loss of bed space. Do not show up with a scheduled entry date.
- **Entry fee of $300** must be paid at time of arrival and is **NON-REFUNDABLE**. Recovery Ventures only accepts payment in the form of **cash, cashier's check or money order**.
- Associates that have previously left Recovery Ventures **against clinical advice** are required to pay a **$400 RE-ENTRY** fee.
- DO NOT bring anything that is not on the approved clothing inventory list. Items brought that are not on this list will be taken and disposed of accordingly.

On a scale of 1 to 10, how serious a problem do you think you have with drugs or alcohol?

(No Problem) 1 2 3 4 5 6 7 8 9 10 (Very Serious Problem)

On a scale of 1 to 10, how motivated are you to make changes in your life at this time?

(Not al all) 1 2 3 4 5 6 7 8 9 10 (Very motivated)

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CLOTHING INVENTORY

The following list must be strictly adhered to. **Any items over the amount specified will be disposed of accordingly and will not be returned at a later time!** ***The personal items should be kept at or below the following***:

Men

10 pants (1 or 2 pair of slacks, black/khaki)
10 shirts (1 or 2 dress shirts, black/white)
10 t-shirts 5- ribbed tank undershirts
5 shorts
1 suit
3 pair of pajamas
1 pair of slippers
1 pair of flip-flops
Necessary toiletries/hygiene items(NO alcohol/aerosol)
10 pair of underwear, 10 pair of socks
1 winter coat
1 jacket
1 Bible, 1 AA/NA Book, 1 Journal
4 pictures (no significant others/spouses, immediate family only)
3 pair of shoes **TOTAL**, 1 dress/work shoes (black non-slip), 1 work boots, 1 sneakers
2 hats
1 Wallet with Social Security Card, Picture ID-**ONLY**
1 alarm clock
1 sunglasses
3 cartons of tobacco products
1 pillow with pillowcase
1 twin sheet set
2 towels, 2 washcloths

Women

All clothing should be Very LOOSE fitting

10 pants (1 or 2 pair of slacks, black khaki)
10 shirts (1 or 2 dress shirts, black/white)
10 t-shirts (NO white or V-neck), 5 undershirts/camisoles
5 shorts (at least knee length)
3 pair of pajamas
1 pair of slippers
1 pair of flip-flops
Necessary toiletries/hygiene items(NO alcohol/aerosol)
10 pair of underwear (NO thongs), 10 pair of socks, 5 bras
1 winter coat
1 jacket
1 Bible, 1 AA/NA Book, 1 Journal
4 pictures (no significant others/spouses, immediate family only)
3 pair of shoes **TOTAL,** 2 pair sneakers, 1 pair work shoes (black non-slip)
2 hats (winter)
1 Wallet with Social Security Card, Picture ID-**ONLY**
1 alarm clock
1 sunglasses
3 cartons of tobacco products
1 pillow with pillowcase
1 twin sheet set
2 towels, 2 washcloths
1 twin comforter

NOTE:* *DO NOT BRING *JEWELRY, WATCH, PERFUME, COLOGNE, BODY SPRAY, SCENTED LOTION,MAKE-UP, TELEPHONES,MUSIC DEVICES, HAIR CLIPPERS/ELECTRIC SHAVERS, STUFFED ANIMALS, LETTERS, BOOKS, MAGAZINES, MONEY, CREDIT CARDS, ADDRESS BOOKS,* ***OR ANYTHING NOT LISTED ABOVE****.*

If you do not have all of the above items, we will do our best over the following weeks to assure that you receive the clothing items you require.

*****You** *WILL NOT* **be allowed to request any items to be sent from home until your first family visit, which is when you make Leadership phase (approximately 6 months).** Birthday and Christmas gifts will be dealt with on a request basis.

Recovery Ventures Corporation will not be responsible for any personal items left behind if you leave against clinical advice. You will be given one business day to make arrangements to pick up your belongings, after that they will be delivered to a local charity as a donation or disposed of in the local landfill. You are encouraged during your stay to not bring anything of sentimental value!!

I understand that if I bring items other than those specifically listed above, the items will be disposed of at the time of my entry into the program and this may result in accountability. The list above is all-inclusive; there are no exceptions.

_____ _____
Print Name (Signature) **Date**

_____ _____
Witness (Intake Coordinator) **Date**

VOLUNTARY

APPLICATION

FOR

ADMISSION

SUBMITTED BY: _____

DATE: _____

Best Number to Reach You at: _____

E-mail: _____

Fax: _____

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Voluntary
Application for Admission

Date: _____

Name:
Last: _____ First: _____Middle: _____ Sex: _____ Race: _____

SSN: _____ DL#: _____ State: _____ License Status: _____ DOB: _____

Most Recent Address: _____

City: _____State: _____ County:_____ Zip: _____

Height: _____' _____" Weight: _____lbs Hair Color: _____ Eye Color:_____

Distinguishing Marks: (Tattoos, Scars, etc.)_____

Marital Status: Married: _____ Divorced: _____ Single: _____ Separated: _____

If married, Spouse's Name _____

Do you have any children? _____ How Many?_____

Child's Name	Who is the child staying with	Child's Age

In case of Emergency, Notify: _____ Phone #: _____

Relationship to Applicant: _____ Emergency Contact E-mail: _____

Parent's Name: _____ Phone #: _____

Address: _____

City: _____State: _____Zip: _____

Have you ever resided in any state other than North Carolina? Y__ N___. If Yes, where? _____
_____

First time applying to RVC? Y__ N__

Have you previously been a resident in RVC? Y__ N__ Did you complete? Y__ N__ Circumstances around discharge.
_____
_____

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Criminal Justice Information

Applications may be submitted and a determination to accept or reject the applicant will be made prior to the scheduled court date. However, all legal proceedings must be completed prior to establishing residency in a **Recovery Ventures** *facility.* ***Failure to disclose pending legal action(s) may be grounds for immediate dismissal from the program*.**

Do you have any outstanding warrants? _____ If Yes, please describe: _____

Do you have any outstanding charges? _____ If Yes, please describe: _____

When is your court date? _____ State and county: _____

Are your represented by an attorney? _____

Attorney's Name: _____Phone #:_____

Address: _____City: _____ State: _____ Zip: _____
***Must provide legal documents pertaining to any and all court cases/judgments/release orders.**

Are you on supervised probation? _____ If Yes, what are the charges? _____

If yes, in what county and state? _____

Probation Information: Officer's Name: _____

Address: _____

City/State/Zip: _____

Phone #:_____

Last Seen/Spoken With: _____

Is your probation officer aware that you are seeking long term treatment? _____

Are you obligated for child support payments? _____ Are payments current? _____

County: _____ Case worker Name: _____

Financial Information

Do you have any outstanding debts (child support, installment loans, IRS, etc.)? _____
If yes, explain? _____

_____.

Do you receive any ongoing financial reimbursement for any reason (disability, trust fund, etc.)? _____
If yes explain? _____

_____

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Medical History Information

Do you have any medical conditions that will limit your activities? _____

If yes, explain: _____

Are you taking any prescription medication(s)? _____

If yes, list all and how long have you been taking this medication? _____
_____

Have you ever experienced or been diagnosed as having any of the following:

_____ Seizures _____ TB _____ Diabetes _____ Hepatitis

_____ Heart Disease _____ Epilepsy _____ Cirrhosis _____ High BP

Are you currently under the care of a physician? _____

Doctor's Name: _____Phone #: _____

Reason(s) for current treatment: _____
_____

List any past mental health hospitalizations:
Hospital name Date(s) Reason
_____
_____
_____
_____
_____

Any history of suicide attempts, suicidal ideations, or other self-harm? _____ If yes explain: _____
_____
_____

Are you currently experiencing any of the above? _____ If so, do you have a plan? _____

If so, please explain_____

Are you having homicidal thoughts? _____ If so, Please explain_____
_____
_____

Have you been tested for HIV/TB? _____ Date: _____ Result: _____

Are you a veteran? _____ Do you qualify for medical benefits? _____

Do you have health insurance? _____
_____

Do you have or maintain a primary residence at this time? ____ Yes ____ No

If NO, where have you been staying/sleeping? _____ Relative ____ Friends ____ Shelter ____ On Street

How long have you been in this situation? _____ Years _____ Months _____ Days

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Educational Information

Did you graduate from high school? _____ Year: _____

If not, highest grade completed? _____

Did you earn a GED? _____ Year: _____

Have you had any college or vocational school training? Y ____ N _____

Name of College/School: _____

Location: _____

Degree/Certificate Received: _____ Year: _____

Employment Information

Are you currently employed? Y__ N__ If yes, where. _____

How Long? _____ Do you enjoy this type of work? _____

What type of work would you like to do? _____

How long has it been since you last worked? Where? _____

Substance Use History **Drug of Addiction: _____**

Drug Age at first use Amount used at peak Current use Date of last use

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever experienced treatment for substance use? Y __ N __. If yes, please describe. (Name, dates, type of treatment, did you complete?, etc.) _____
_____
_____
_____

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RELEASE OF INFORMATION AUTHORIZATION

Client Name:_____

Date of Birth:_____ Social Security Number: _____

I, _____, hereby authorize _____
(Client's Name) (Facility, Physician, and address of person releasing information)

_____

to release/exchange specified information in my client record to: _____
(Recipient Name and Address)

_____

This data shall include (Nature & Extent of Information)
Specify Time Period: _____

___Summary of Evaluation & Treatment
___ Admission Assessment/Screening
___ Alcohol or Drug History & Treatment
___ Progress Notes
___ Discharge Summary
___ Psychiatric Evaluation & History
___ Human Immunodeficiency (Virus) (History & Treatment)
___ Acquired Immunodeficiency Syndrome (Aids History & Treatment)
___ Treatment Plan & Diagnosis
___ Medication History
___ Psychological Evaluation
___ Financial Information
___ Educational Information
___ Attendance

___ Other: _____

I understand this information will be used for:

___ Evaluation & Treatment Planning
___ Case Management Services
___ Other:_____
___ Referral
___ Continuity of Care

I hereby request and authorize the above named agency, organization or individual who possesses information relative to the client named above to release information, as specified, to the agency, organization or individual named on the request. I understand that the information to release may include information regarding drug abuse, alcohol abuse, sickle cell anemia, or psychological or psychiatric information.

I certify this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by state and federal law. This consent shall be valid for a period not to exceed one year. I further acknowledge that I may revoke this consent, in writing, at ANY time except to the extent that action based on this consent has been taken.

Client:_____ Legal Representative:_____

Date:_____ Witness:_____

Person Releasing Information:_____ Date:_____

Over the Counter Medication Administration Acknowledgement
&
Statement of Personal Responsibility

These are the over the counter medications that Recovery Ventures Corporation provide on an as needed basis. Please review the list below and check those medications that you are able to take without known adverse reaction.

Allergy Preparations
__ Benadryl tablets/ointments
__ Claritin

Analgesics
__ Tylenol
__ Aspirin
__ Excedrin
__ Ibuprofen (Motrin, Advil)
__ Aleve

Cough & Cold Preparations
__ Chlorpheniramine and acetaminophen (Coricidin)
__ Guaifenesin elixir (Robitussin, Tussin)
__ Vapor rubs, sore throat lozenges/sprays
__ Clemastine (Tavist)

Digestional Aides
__ Aluminum and magnesium hydroxide with simethecone (Maalox-antacid/anti-gas)
__ Bisacodyl (Dulcolax-stool softeners/laxatives)
__ Bismuth subsalicylate (Pepto-bismol, Kaopectate)
__ Calcium Carbonate (Tums, Rolaids)

Nutritional Supplements
__ Vitamins
__ Fiber
__ Calcium
__ Zinc
__ Fish Oil

Topical Preparations
__ Hydrocortisone ointments
__ Zinc oxide lotion (Calamine)
__ Bacitracin/neomycin/polymyxin B (Neosporin, Triple antibiotic ointments)

Miscellaneous
__ Opthalmalic Solutions: (Saline, Allergy drops)
__ Antiseptics: (Betadine, Rubbing Alcohol, Hydrogen Peroxide, Bactine, camphophenic)

OTC Med list and use of all items checked by associate approved by:

Sharon Sweede MD
Sharon Sweede, M.D.

By my signature below, I acknowledge that during my residency at Recovery Ventures Corp., I am allowed to take only those over the counter medications that I have indicated above with a check mark. Further, I hereby agree to hold Recovery Ventures Corp. harmless if I take any over the counter medication not checked off above.

_____ _____
Associate Name Date

_____ _____
Witness Date

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Medication Guidelines

To Whom It May Concern:

Applicants currently taking prescription medications will need to have the following documents in order to successfully enter the program:

1. A standing order from the prescribing doctor, (that exactly matches the Rx. Label on the bottle) including the name of the medication, strength, frequency of dose **(needs to read "daily" or "qd"; NOT "twice daily" or "bid", morning, bedtime etc…example: 2 tabs daily/not 1 tab twice daily)**, and route of the medication.
2. A self-administer note from the prescribing doctor granting permission for the patient to administer their own medications.
3. A 90 day supply of the medication and a 9 month prescription or as close to it as possible.

Before arrival, the applicant must send all proper documentation, as well as enough money to pay for the second 90 day supply of refills for their medications. Recovery Ventures Corporation is not a medical facility and will not be responsible for any medical bills.

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Self-Administration Order

Date: _____

Patient: _____

Date of Birth: _____

Medication(s), dosage(s), route, frequency:

_____
_____
_____
_____
_____
_____
_____
_____

Patient is able to administer his/her own medication(s).

Provider Signature: _____

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Contact Information For Responsible party

Associate Name: _____

Name: _____

Mailing Address: _____

_____

_____

Email Address: _____

Home Phone: _____

Work Phone: _____

I give Recovery Ventures permission to send any bills pertaining to the noted associate to me for payment. I also give them permission to contact me concerning any medical issues that might arise during this associates stay at Recovery Ventures.

Signature: _____Date: _____

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Responsible Party Payment Contract

I fully understand that Recovery Ventures Corporation is not a medical facility and is not responsible for any medical bills or the cost of medication for associates in residence at Recovery Ventures.

I, _____(i.e. parent, guardian, payer, etc.), accept full responsibility for any and all medical bills and cost of medications for _____ (program associate) while they are a participant in the Recovery Ventures program. I am aware that the cost of the medication, although predetermined, may be subject to change during the course of the program.

I am also aware that the cost for three (3) months of medication is to be paid at the time of intake, in addition to the entry fee. Once this money runs out, payment will then be due before additional refills can be obtained. I understand that it is not Recovery Ventures responsibility to bill me or remind me of payment. I also understand that any breach of this contract will result in evaluation of the associates stay at Recovery Ventures.

By signing this I acknowledge that I understand all conditions and agree to abide by them. I take full responsibility of all payments and conditions. I also understand that in the case that the associate leaves the program or gets terminated from the program all funds remaining will be returned to the responsible party, not the associate. Please contact our office to make these arrangements.

Responsible party print name_____

Responsible party signature _____ Date: _____

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Unauthorized Medication List

Recovery Ventures Corporation does not allow residents to take the following medications:

- **Opioids**

Morphine	Dilaudid	Vicodin	Ativan	Lortab
Codeine	Buprenorphine	Demerol	Klonopin	Percocet
Oxycodone	Methadone	Darvon	Darvocet	Suboxone

- **Central Nervous System (CNS) Depressants**
  Used to treat anxiety and sleep disorders.
  1. **Barbiturates**

Mebaral	Phenobarbital
Nembutal	Seconal

  2. **Benzodiazepines**

Valium	ProSom	Flurazepam	Triazolam	Klonopin
Librium	Ativan	Restoril	Xanax	

- **Stimulants**

Dexedrine	Adderall	Strattera
Ritalin	Cylert	Medadate
Concerta	Clonidine	Ephedrine

- **Antipsychotics**

Seroquel	Haldol	Clozaril
Risperdal	Thorazine	Lithium

- **Muscle Relaxers**

Flexeril	Cycoflex	Zanaflex
Soma	Skelaxin	

- **Anti-Depresants (Sedating)**

Elavil	Remeron	Tofranil	Buspar
Trazadone	Pamelor	Sinequan	Visteril

Recovery Ventures Corporation doesn't allow the medications listed above and will most likely not accept any that may cause similar reactions.

We have found that certain over the counter medications have the potential for abuse. We only allow clients to take OTC's that are provided by the facility, and ordered by a doctor. Residents are not permitted to bring in or hold their own OTC medications.

Please call us if you have a question about a client's medication. Often, it is possible to replace one unacceptable medication with one that is acceptable to us and just as effective for the client's condition. If this is the case, this must take place before admission in order to ensure efficacy.