Instructions:

1. Complete all fields, Incomplete requests will be returned.
2. The pharmacist making the request must sign the request. **STAMPED SIGNATURES ARE NOT ACCEPTED.**
3. Fax or mail this form to NDPDMP, Board of Pharmacy's office.

Fax Number: (701) 328-9536

Mailing Address: ND State Board of Pharmacy
Attn: PDMP
1906 E. Broadway Ave.; PO Box 1354
Bismarck, ND 58502-1354

4. Please call the board's office if you have any questions regarding the prescription drug monitoring program. (701) 328-9537

Profile Request-Pharmacy

North Dakota Prescription Drug Monitoring Program (NDPDMP)
North Dakota Board of Pharmacy
Patient Profile Request For Controlled Substance Prescription Information

Contacts:
Howard C. Anderson, Jr, Executive Director, ND Board of Pharmacy: ndboph@btinet.net
Patricia M. Churchill, R.Ph., Program Director, NDPDMP: ndbophpdmp@btinet.net
Kathy R. Zahn, Program Assistant, NDPDMP: ndbophpdmp@btinet.net

Patient's Information

Name: _____ Date of Birth: _____
First, Middle, Last

Address: _____ AKA (if any): _____

City, State, Zip: _____ Date Range: _____
The time period you wish your search to include (ex. ALL or Jan07 – Jan08)

Pharmacist Information

Name: _____ License No.: _____
First, Last ,Title

Pharmacy Name: _____ ND Pharmacy Permit No.: _____

Address: _____ Phone: _____

City, State, Zip: _____ **MAIL RESPONSE** ☐
CHECK THE BOX IF YOU WOULD LIKE THE PROFILE MAILED TO YOU, AND NOT FAXED

Fax: _____

I certify this patient is under my medical care or has requested care from me and that I am currently employed as a pharmacist at the above listed pharmacy.

X _____
Signature of Pharmacist Making Request *Date*

THIS PROFILE WILL BE FAXED TO THE PHARMACY, ATTENTION THE REQUESTING PHARMACIST, UNLESS REQUESTED TO BE SENT BY MAIL, REQUESTS RECEIVED AFTER 4PM ARE SUBJECT TO NEXT DAY PROCESSING.

For Office Use Only

Date/Time Rec'd: _____ Date/Time Faxed Back: _____

Mailed On: _____ Prepared By: _____
Initials

Notes:

Report Number:

Rx. *Pres.*