

**WYOMING STATE BOARD OF PHARMACY
PRESCRIPTION DRUG MONITORING PROGRAM**

**PATIENT PROFILE REQUEST FOR CONTROLLED SUBSTANCE PRESCRIPTION
INFORMATION (Practitioner)**

Instructions:

1. Please complete all blanks. Incomplete requests will be returned.
2. **The practitioner must sign the request.**
3. Request may be faxed or mailed to the board's office.

Fax Number: (307) 634-9184

Mailing Address: WY State Board of Pharmacy
1712 Carey Avenue, Suite 200
Cheyenne, WY 82002

4. Please call the board's office if you have any questions regarding the prescription drug monitoring program. (307) 634-9636
Contacts: David N Wills, Data Management Specialist (dwills@wyo.gov)
Mary Walker, Executive Director (mwalke2@wyo.gov)

Patient's Name: _____ AKA (if any) _____

Patient's date of birth: _____

Patient's Address: _____

I certify this patient is currently under my medical care.

X

Signature of Practitioner

X

Date

X

Printed Name of Practitioner

DEA Number (please print clearly): _____

Practitioner Fax: _____

Practitioner Telephone: _____

Practitioner Address: _____

Practitioner city, state, zip code: _____

This profile will be faxed to the practitioner's office unless requested to be sent by mail.

Check this box if you want the patient's report sent by mail to the practitioner's office.

Date received: _____ Time received (if faxed request): _____

Profile prepared: _____ and submitted to practitioner via FAX @ _____ or by US Mail on _____