Healthcare Branch
Colorado Prescription Drug
Monitoring Program (PDMP)

Colorado State Board of Pharmacy
Prescription Drug Monitoring Program

Confidential Patient Information Request for Non-Colorado Prescribers or Pharmacists

Prescriber or Pharmacists Information:

Name: ______________________________ Profession: ________________________

Address: _____________________________ City/State/ZIP: ______________________

Phone number: ________________________ Driver's License Number: ________________

State of Licensure: _____________________ License number: _______________________

DEA Registration: _______________________

Mailing address: __________________________ City/State/ZIP: _______________________
(The patient report will be mailed to this address)

Provide Copies of the Following:
a) Driver's License from state of residence.
b) Copy of relevant license (medical, physician assistant, etc.) from state of issuance; and
c) Copy of DEA Registration

Patient Information:

Name: _________________________________ Date of Birth: ________________________

Address: ______________________________ City/State/ZIP: _______________________

Date range for the patient report ____________________

I acknowledge and verify the information I am accessing is for a patient I am currently treating. I understand that if I release, obtain, or attempt to obtain information from the program in violation of CRS 12-42.5-404, I may be fined for each violation.

Prescriber or Pharmacists Signature: _____________________________ Date: _________________

Mail to 1560 Broadway, Ste. 1350, Denver, CO 80202
Fax to 303-869-0133/e-mail to: pdmpinqr@state.co.us