



Nova Scotia Prescription Monitoring Program
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 T 902.496.7123 F 902.481.3157
 TF 1.877.476.7767
 www.nspmp.ca

**Request for a Monitored Prescription History
 (One request per form)**

Requested By: _____ **Title:** _____

Police Agency: _____

Contact Number: _____ **Fax:** _____

Patient Name: _____

Patient Address: _____

Healthcard Number: _____ **DOB:** _____

Period Requested (Claim Dates): _____ to _____
 YYYY/MM/DD YYYY/MM/DD

Reason for Request (must be clear and justifiable or the information cannot be released):

Signature: _____ **Date:** _____

Note: In accordance with the Nova Scotia Prescription Monitoring Program's mandate to promote the appropriate use; and reduction of misuse and/or abuse of monitored drugs, the Program has the ability to share information provided on this form with the individual's prescriber and/or pharmacy.

Please check if you would like this information shared with appropriate prescribers and/or pharmacies. The NSPMP may contact you for clarification or additional information regarding this request.

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