Request for KASPER Patient Report

Please PRINT or TYPE Information on all lines

Patient Name _____ (First) _____ (Last)

Address _____

City _____, _____ (State) Zip _____

ID _____
ID Type (check one): ❒ SSN ❒ Drivers License

DOB _____ (mm) / _____ (dd) / _____ (yyyy)

Is/was the subject known by other names? ❒ Other Names *

Does/did the subject have other addresses? ❒ Other Addresses **

Date Range for Report

From ____ (mm) / ____ (dd) / _____ (yyyy) To ____ (mm) / ____ (dd) / _____ (yyyy)

DEA #: _____
Please Print

Requestor Name: _____
Print Name of Prescriber or Pharmacist

Fax Back Number: _____

* Other Names (check Other Names box, above)

1. _____ (First) _____ (Last)
2. _____ (First) _____ (Last)
3. _____ (First) _____ (Last)

** Other Addresses (check Other Addresses box, above)

1. _____
2. _____
3. _____

Requestor Details

_____
Prescriber or Pharmacy Address

_____
Prescriber or Pharmacy City, State Zip

_____
Facility or Pharmacy Contact Name

_____
Prescriber or Pharmacy Telephone #

I certify that the information will be used for the purpose of providing medical or pharmaceutical treatment to a current or prospective patient.

_____
Requestor's Signature (Prescriber or Pharmacist)

Limit 15 Requests per Fax

For KASPER Staff Only

Cabinet for Health and Family Services
Office of Inspector General / Division of Audits and Investigations
Drug Enforcement and Professional Practices Branch
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ekasper.admin@ky.gov
Fax 502-564-7468

Kentucky UNBRIDLED SPIRIT