TENNESSEE DEPARTMENT OF HEALTH
TENNESSEE BOARD OF PHARMACY
CONTROLLED SUBSTANCE MONITORING DATABASE ADMINISTRATOR
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
TEL: (615) 253-1305 FAX: (615) 253-8782 EMAIL: CSMD.ADMIN@TN.GOV

DRUG COURT TREATMENT PROGRAM APPLICATION REQUEST FOR PATIENT PROFILE

Please provide the information requested below. (**Please Print**) Case #: _____

Patient Information:

Full Name of Patient:	Maiden Name:
Street Address:	Alias:
City:	State:
Zip Code:	Telephone Number: ( )
Social Security Number:	Birth Date:

Specific Time Period to be covered in report:

Start Date:	End Date:

_____ Judge's Initials

The patient on this form is a current participant in the Drug Court Treatment Program in my district, and I have a reasonable belief that this patient may not be in compliance with the guidelines or rules pertaining to use of controlled substances required for participation in this drug court program.

How do you want the report returned to you? ☐PDF ☐XLS ☐BOTH

Requestor Information:

Drug Court Judge Name:	Agency Name and Judicial District:
Business Street Address:	City, State, Zip Code:
Business Telephone Number: ( )	Drug Court Judge Email:
District Attorney General Name:	District Attorney General Email:

Drug Court Judge Signature:	Date:
District Attorney General Signature:	Date: