



## Patient Information

Male / /  
 Female

Full Name \_\_\_\_\_ Birthdate (MM/DD/YY) \_\_\_\_\_

Address \_\_\_\_\_

Shipping or Alternate Address (if different than above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

## Secondary Contact

Full Name or Secondary Contact \_\_\_\_\_

Relationship To You \_\_\_\_\_ Phone Number \_\_\_\_\_

## Your Physician

Primary Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_ Fax Number \_\_\_\_\_

## Medication Being Ordered (Attach Additional Sheet if Required)

| Brand Only  | Generics Permitted       | Medications | Strength | QTY                | Price   |
|---|--------------------------|-------------|----------|--------------------|---------|
| <input type="checkbox"/>  | <input type="checkbox"/> | (1)         |          |                    |         |
| <input type="checkbox"/>  | <input type="checkbox"/> | (2)         |          |                    |         |
| <input type="checkbox"/>  | <input type="checkbox"/> | (3)         |          |                    |         |
| <input type="checkbox"/>  | <input type="checkbox"/> | (4)         |          |                    |         |
| <input type="checkbox"/>  | <input type="checkbox"/> | (5)         |          |                    |         |
| Note: Each prescription should request a <b>3-month</b> supply of medication with <b>3-refills</b> indicated.       |                          |             |          | Add \$10 Shipping* | \$10.00 |
| *The shipping fee is a flat rate of \$10.00 per package (not per drug, but per shipment) within the continental US. |                          |             |          | <b>Total</b>       |         |

## Other Medication You Are Currently Taking

This is for our records only and will be kept strictly confidential. Listing other medications that you are currently taking will help us create a more complete medical history for you.

## Medical History

Please list present illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. (attach separate sheet if required).

## Patient Counselling Information

Yes, Would you like a pharmacist to call you to provide patient counselling?  
 No, Do you have any known drug allergies? If yes, please enter the drug(s) you are allergic to:

## Payment Information

**VISA**  
 Cardholder's Name \_\_\_\_\_

**MasterCard**  
 Credit Card Number \_\_\_\_\_ / \_\_\_\_\_  
Expiry Date

**Check**  \_\_\_\_\_  
Cardholder's Signature

Referred By: **OCs**  
Full Name \_\_\_\_\_ Phone \_\_\_\_\_

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I certify that I have read and understood the terms of agreement and that the information provided by me is accurate and true.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Send completed PATIENT FORM and your PRESCRIPTION by toll free fax: 1-866-324-9692  
or MAIL your PATIENT FORM and PRESCRIPTION to: 302 Keewatin Street, Winnipeg, MB, Canada R2X 2R9

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**YOUR PRESCRIPTIONS** ( Attach Here )



**(Please ensure that we can see the entire prescription)**

Please use additional pieces of paper if you cannot fit all of your prescriptions in the designated area