



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 <u>3-month</u> supply of medication with <u>3-refills</u> indicated.				Add \$10.99 Shipping*	\$10.99
*The shipping fee is a flat rate of \$10.99 per package (not per drug, but per shipment) within the continental US.				Total	

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

AM, Pharmacists are required to counsel patients. When would you like to be contacted?
 PM, you like to be contacted?

Yes, Do you have any known drug allergies? If yes, please enter the drug(s) you are allergic to:
 No,

Payment Information

VISA

Cardholder's Name

MasterCard
 _____ / _____
Credit Card Number Expiry Date

Check **X**

Cardholder's Signature

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

Referred By:

Full Name

Phone

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