

NEW PATIENT ORDER FORM

Mailing Address:

PO BOX 61067 Grant Park, Winnipeg, Manitoba Canada R3M 3X8

PERSONAL INFORMATION Male				MEDICATIONS TO ORDER Please enter the quantity and listed price for the medication(s) you wish to order, as obtained through our website or customer service center. An original prescription from your doctor's office is required (faxed, mailed, emailed or called in from your				
Full Name (please prir	nt clearly)		Female	doctor). All orders at			QTY	PRICE
Street Address			a)	EQUIVALENT OK?	MEDICATION	STRENGTH	T	PRICE
City	State	Country	Zip Code	\$ 				
City	State	Country	Zip Code	9				
Phone (Home)		Phone(Other)						
Emoil		Birth date (MM/DD/	// \	9		91	JB TOTAL:	
Email		Birtir date (MiM/DD/	11)	8 1			SHIPPING:	
Best time to be contact		TOTAL:						
Please check if you	are placing thi	is order for a pet.		-			TOTAL	
Cat Dog	Othe	ers						
	_	(Please specify)						
	n-Smoker	Weight:	Height:					
Pregnant Nur	sing?							
			ALLERGIE	:S				
Do you have any seve	ere allergies?	Yes No						
Please list the following	g severe allerg	gies:						
Are you currently takir Please list the followir	• •	s, herbs or minerals?	Yes No					
Do you have any med	ical condition c	or histor our Pharmacy o	department should be awa	are of?				
Do you currently take	other medication	ons aside from what yo	u are placing an order for					
			PAYMENT OP					
Pay by Credit				Personal Chec			I) US	A Only
Please call r	ne to obtain my	y credit card information	=	k information "or		Mailing	g Address:	
				,	OIDED check b		PO BOX 61	1067 Grant Park
Please note that in order to comply with the Payment Card Industry (PCI) Security Standard Council's requirements for the protection of your credit card information we are only able to accept your card information via telephone or through our				Fax [Email	Mail		eg, Manitoba la R3M 3X8
	rdering system.	card information via telephon	e or inrough our	I will pay via ch	neck, and mail it to	-	-	
FIRST TIME PATIENTS (Please fill out this section if you are a first time patient, or to update your information.)				PRESCRIPTION SUBMISSION (Please select one of the three options below.)				
(Please IIII out triis s	•	·	poate your information.)	_		·		
Your Physician Primary Physician's Name				Option 1. Contact My Doctor's office via fax Note: We will attempt to contact your doctor's office via fax up to 4 time as majority of the doctor's offices in the USA prefer to respond to prescription requests submitted via fax. This allows us to avoid any additional delays. However, you contacting your doctor's office directly to have the prescription sent to us via fax is preferred.				
Clinic Name, Street Ad	ddress			_			waa aul4!	
City State Country Zip Code				Option 2. Contact Local Pharmacy for Prescription transfer request.				
,		,		Note: We will at	tempt to contact yo	ur local pharmacy	via tax up to	4 times.
Phone Number	Ext.	Fax Number		Option 3. M	ail or Fax Your	Prescriptions	;	
				Fax: 1 (888)	552-4019 Ma	iling Address:	:	

Please use 3 forever stamps/\$1.15 in postage as you are sending your document via international mail. Failure to do so may result in your mail being lost. Keep in mind it may take 7-10 business days to receive international mail.

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