Canada Drugs®

New Patient Order Form

PHONE: 1-800-CAN-DRUG (226-3784) Direct Dial: (204) 949-1394
FAX: 1-800-988-5440 Direct Dial: (204) 224-2736
INTERNET: www.CanadaDrugs.com Email: info@canadadrugs.com
MAILING ADDRESS: 24 Terracon Place, Winnipeg, Manitoba, Canada, R2J 4G7

Personal Information

_____ ☐ Male ☐ Female
Your Full Name (please print clearly)

Street Address

City State/Province Country Zip/Postal Code

Phone (Home) Phone (Other)

Email Birthdate (MM/DD/YY)

Best time to be contacted

Height: (Feet) (Inches) Weight: (Pounds)

☐ Smoking ☐ Currently pregnant or attempting to get pregnant

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No
If yes, what are they:

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in from your Doctor). **PRICING IN $US DOLLARS.**

Would you like to receive a call to remind you of future refills? ☐ Yes ☐ No

Please check if you are placing this order for a pet.
☐ Cat ☐ Dog ☐ Other (please specify) _____

Pet Name: _____

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
	*FREE for the US (incl. Costa Rica), Canada, and UK. ALL OTHER COUNTRIES $24.		SHIPPING:	
			TOTAL:	

Medication, OTC, Herbal Products You Are Currently Taking

(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

Secondary Contact

Full Name of Secondary Contact

Relationship To You Phone Number

Referral Rewards Program

Save 25% on this your first order! Simply share with us who referred you.

Full Name of person who referred you Phone Number

Referrer must be an exsiting patient with a previous order to qualify

☐ **Please send me a Referral Rewards Program package**

Visit **www.canadadrugs.com/referralrewards** for more information

Payment Options *(Please Select One)*

1 (ACH) Direct Bank Withdrawal

☐ **I will fax or email a signed, void check to one of the following:**

Email: info@canadadrugs.com
Fax: 1-800-988-5440

2 PERSONAL CHECK

☐ **I will mail a written personal check to:**

Canada Drugs
24 Terracon Place
Winnipeg, MB, Canada
R2J 4G7

OR

3 CREDIT CARD ☐ Visa ☐ Mastercard ☐ AMEX (Sorry, NO Discover)

Cardholder's Name

Cardholder's Address

City State/Province Country Zip/Postal Code

Credit Card Number Expiry (MM/YY) CVV Code

NOTE: Not all pharmacies are able to take Credit Cards for payment. You may call ahead to verify, or we will call you if alternate payment needs to be arranged.

Patient Authorization *(Please Check One)*

Canada Drugs™ Customer Care operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales as between the Canada Drugs™ authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

☐ **"I am over the age of majority, and:**

1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.
2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.
4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."

OR

☐ **"I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."**

Patient's Signature Date (MM/DD/YY)

REF NUM

Canada Drugs®

Prescription Submission

PHONE: 1-800-CAN-DRUG (226-3784) Direct Dial: (204) 949-1394

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INTERNET: www.CanadaDrugs.com Email: info@canadadrugs.com

MAILING ADDRESS: 24 Terracon Place, Winnipeg, Manitoba, Canada, R2J 4G7

Please use this form to submit your prescription(s), and send it back to us to complete your order.

Full Name _____ Patient ID: ☐☐☐☐☐☐☐☐

Phone Number _____ Order ID: ☐☐☐☐☐☐☐☐

Your Physician

Primary Physician's Name _____ Clinic Name, Street Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____

Phone Number _____ Ext. _____ Fax Number _____ Email _____

☐ Option 1 (FASTEST): Email or Fax a copy of your prescription(s) and then mail originals.

Scan or use your camera (smartphone) to take a clear picture of your original prescriptions, then email them in full quality to:

To: prescriptions@canadadrugs.com
Subject: Prescription(s) for (type your name)

OR

Fax: 1-800-988-5440

Sending the scan will allow your order to continue processing. Please mail your original prescription to:

Canada Drugs
24 Terracon Place
Winnipeg, Manitoba
Canada
R2J 4G7

☐ Option 2: Contact Your Doctor*

Please list the medications you would like us to call your doctor about.

Drug Name	Strength	Directions	Rx Number

*** Contacting your doctor is only available to residents of the United States and Canada**

REF NUM