CanDrugstore.com

**Ordering Your Medication is Easy With a Few Simple Steps!**

**"Need Help!"** Call Customer Care Toll Free **1-866-444-6376**

1. Confirm online drug prices and availability & write them on this order form.
2. Complete all sections and sign this order form. This will be required the first time you register with us.
3. Mail or fax the prescription(s) and photo ID along with the completed order form to:

**Mail to: #109 - 7938 128th Street Surrey, B.C. Canada V3W 4E8** **Fax#: 1-866-444-6378**

## YOUR PERSONAL INFORMATION

Full Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Day Phone: (  )_____

Evening Phone: (  )_____

Email Address:_____

How did you hear about us:

☐ Friend ☐ Flyers ☐ Website ☐ Radio ☐ Television

☐ Newspaper/ Magazine ☐ Search Engine ☐ Associations

☐ Other_____

**Referral/ Promo #** (optional)**:**

## YOUR MEDICAL PROFILE

Birthdate: _____/ _____ /_____ (month / day / year)

Height:_____ Weight:_____

☐ Male ☐ Female

| | YES | NO |
|---|---|---|
| Have you had a physical exam in the last (12) months? | ☐ | ☐ |
| Are you pregnant (or) nursing? | ☐ | ☐ |
| Do you drink alcohol? | ☐ | ☐ |
| Are you a smoker? | ☐ | ☐ |
| Do you have any known allergies (incl. drug allergies)? | ☐ | ☐ |

If YES, please list drug and description of reaction with date below:

_____

_____

_____

_____

_____

## MEDICAL HISTORY

**Please select all conditions that apply to you:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Alcoholism | ☐ Alzheimer's | ☐ Anemia | ☐ Asthma | ☐ Bone/ Joint Disorder | ☐ Blood Disorder |
| ☐ Cancer | ☐ Chrohns/ Colitis | ☐ Cholesterol | ☐ Depression | ☐ Diabetes | ☐ Emphysema |
| ☐ Fluid Retention | ☐ Glaucoma | ☐ Heart Disease | ☐ High Blood Pressure | ☐ Kidney Disorder | ☐ Liver Disease |
| ☐ Lupus | ☐ Migraines | ☐ Muscle Disorder | ☐ Nutrition Deficiency | ☐ Parkinson's Disease | ☐ Psychiatric Disorder |
| ☐ Rheum / Arthritis | ☐ Stroke | ☐ Thyroid Disease | ☐ Ulcers | ☐ Recent Surgery | ☐ Recent Hospitalization |

If checked above, please provide details:

_____

_____

_____

**YOUR PRIMARY PHYSICIAN**

Physician's Full Name:_____

Phone #: (  )_____ Fax #:(  )_____

## MEDICATION HISTORY

| **Drug Name and Strength** (e.g. Lipitor 20mg) | **Directions** (e.g. "1 tablet once daily") | **Comments** (How Long? Is it Effective? Diagnosis?) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

**The pharmacy can only provide appropriate care if information provided is accurate and complete**

## Final Check List

- Double check that all sections of this order form is complete.
- Call our customer care hotline to confirm drug price and availability.
- Make sure you have signed both the **required signatures** on this 2-page order form.
- Please fax/mail the prescription(s) you are ordering along with a photo ID and this completed 2-page order form.

**Fax this order form and your prescription sheets to our 24-hour Customer Fax 1-866-444-6378**

# Medication Order



Please list all medications (including OTC) you are currently ordering. For all medications being ordered, list the quantity you require, whether you want generic, and the price. Please find prices by calling our toll free line at 1.866.444.6376. Order total may vary depending on prescription. Total the amount of your order and add one shipping charge of $9.95.

| DRUG NAME and STRENGTH (mg) | GENERIC | OVERSEAS | QTY | PRICE |
|---|---|---|---|---|
| 1. | ☐ | ☐ | | $ |
| 2. | ☐ | ☐ | | $ |
| 3. | ☐ | ☐ | | $ |
| 4. | ☐ | ☐ | | $ |
| 5. | ☐ | ☐ | | $ |
| 6. | ☐ | ☐ | | $ |
| 7. | ☐ | ☐ | | $ |
| 8. | ☐ | ☐ | | $ |
| 9. | ☐ | ☐ | | $ |

| | YES | NO | | |
|---|---|---|---|---|
| Will you accept generic version(s) of the medications? (if your doctor authorizes) | ☐ | ☐ | Subtotal: | _____ |
| Will you accept overseas medication? | ☐ | ☐ | Shipment Cost: | **$9.95** |
| Would you like to speak with a pharmacist? | ☐ | ☐ | Total (US$): | _____ |

**PAYMENT METHOD:** ☐ Visa ☐ MasterCard ☐ Cashier's Check ☐ Int'l Money Order

**If you are paying by Credit Card, fill this section out**

_____ _____
Credit Card Number CVV2*

_____ _____
Expiry (MM/YY) Cardholder's Name (as it appears on the card)

***CVV2 = Last 3 digits on the back of the card**

_____ _____ _____ _____
Cardholder's Street Address City State Zip Code

_____ _____
Cardholder's Signature Date

## CUSTOMER AGREEMENT

**The undersigned, (hereinafter the "Client") being over the age of 21, hereby agrees that:**

1. I am not legally restricted from making my own medical decisions and grant Canada Online Healthlink Inc. on behalf of CanDrugStore.com, its pharmacy network, affiliates, agents, related companies, subsidiaries and parent companies (hereinafter the "Providers") a power of attorney for the limited purpose of signing any document required by Canadian authorities to permit the delivery of the ordered products to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.
2. I confirm the prescription submitted was lawfully obtained from a physician licensed to practice within my place of residence, that the prescription is for my personal use, that the prescription has not been altered or filled prior to submission and that the medications will only be used as re-prescribed by a licensed Canadian physician who will re-issue the prescription, if deemed appropriate.
3. I affirm that, to the best of my knowledge, I have fully and truthfully disclosed all pertinent information and documentation to the Providers and that the Providers have only relied on and will continue to rely on the information provided by my physician and me. I accept that I am responsible for notifying the Providers of any change in my medical profile and authorize the providers to communicate with my physician if they so seem it advisable. I affirm that the Provider's review of my medical information is for the sole purpose of verifying the providers to communicate with my physician if they so deem it advisable. I affirm that the Provider's review of my medical information is for the sole purpose of verifying the appropriateness of the prescription and is not intended to diagnose any medical condition nor is it a substitute for my duty to consult my physician.
4. I affirm that I have been taking the prescribed medication for at least 30 days prior to submission, that I have had a medical examination in the past twelve months, that I will continue being monitored by my physician and that I will promptly contact my physician in the event of adverse effects from the use of pharmaceuticals.
5. I understand the medications will be dispensed in their original manufacturer's packaging or in child resistant package, unless specified.
6. I agree that once shipped, no medications may be returned for refund or exchange and that orders cancelled before shipping will be charged US$10.00 per prescription.
7. I release and discharge the Providers, its officers, directors, employees and agents of any and all liabilities, claims and causes of action with respect to error, omissions, negligent acts or misrepresentations by my physician and the Canadian physician except as appropriate and usual when pharmaceuticals are provided, and also for the late delivery, non-delivery or missed delivery of the products by the company or agency responsible for transportation. I further agree that the Canadian physician shall not be liable for any liability, claim, loss, damage or expense caused directly or indirectly by any inadequacy, deficiency or unsuitability of the Canadian physician's review of my medical information and original prescription nor on the re-issue of the prescription.
8. I acknowledge and agree that I am using CanDrugStore for the sole purpose of helping me comply with the documentation and communication necessary to service my request. I understand CanDrugStore is not a pharmacy and is not the seller and handler in any form or manner of prescription drugs and does not provide medical advice.
9. I agree that any dispute that arises between me and the Providers shall be governed by the laws of the province of British Columbia and agree that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute.
10. I have read and understood the terms and conditions set out in this Customer Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns, to be bound by these terms and conditions.

► _____/ _____/ _____
Patient Signature Print Name Date