

**CANADIAN MED SERVICE ORDER FORM**



Please fax back to toll-free 1-866-982-9542

**(Please Print)**

**YOUR ORDER**

DRUG NAME	Strength	Quantity	Price (USD)
*Attach an additional sheet if you require more space		<b>Shipping</b>	<b>\$10.99</b>
		<b>TOTAL</b>	

**YOUR PRESCRIPTION(S):**

- Enclosed     
 My Doctor is faxing them to you     
 Please contact me

**PERSONAL INFORMATION: (please print)**

YOUR FULL NAME: \_\_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_\_ (MM/DD/YYYY)      Weight: \_\_\_\_\_ lbs

Shipping Address: \_\_\_\_\_

City: \_\_\_\_\_      State: \_\_\_\_\_

Country: \_\_\_\_\_      Zip: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Primary Physician Name: \_\_\_\_\_

Street: \_\_\_\_\_      Phone: (      ) \_\_\_\_\_

City: \_\_\_\_\_      Fax: (      ) \_\_\_\_\_

- DRUG PACKAGING:**     Please supply me with child resistant containers/packaging
- No, do not supply me with child resistant containers/packaging

**PAYMENT INFORMATION:**

Payment Type:       VISA               MASTERCARD  
    CHEQUE OR INTERNATIONAL MONEY ORDER

CARD NUMBER: \_\_\_\_\_

CVV NUMBER: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_

Card Holder's Signature: \_\_\_\_\_

Card Holder's Address:  same as above

Telephone: (      ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Zip: \_\_\_\_\_

**MEDICAL INFORMATION:**

- |  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> Memory Loss                                   | <input type="checkbox"/> Psychosis               | <input type="checkbox"/> Bronchitis & Emphysema | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Urinary Incontinence        |
| <input type="checkbox"/> Osteoporosis                                  | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Chronic Headaches              | <input type="checkbox"/> Gout                        |
| <input type="checkbox"/> High Cholesterol                              | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Parkinson's Disease    | <input type="checkbox"/> Thrombo-embolism               | <input type="checkbox"/> Rosacea                     |
| <input type="checkbox"/> High Blood Pressure                           | <input type="checkbox"/> History of Stroke       | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> History of Intestinal Bleeding | <input type="checkbox"/> Community-Acquired Pneumoni |
| <input type="checkbox"/> Arthritis - Rheumatoid, Osteoarthritis, Lupus | <input type="checkbox"/> Angina                  | <input type="checkbox"/> Depression             | <input type="checkbox"/> Inflammatory Bowel Syndrome    |  |
| <input type="checkbox"/> Seizures                                      | <input type="checkbox"/> History of Heart Attack | <input type="checkbox"/> Glaucoma               |   |  |
| <input type="checkbox"/> Diabetes                                      | <input type="checkbox"/> Cancer (describe below) | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Prostate Enlargement           |  |
|  | <input type="checkbox"/> Smoker?                 | <input type="checkbox"/> Thyroid disorders      |   |  |

**PLEASE LIST ON THE NEXT PAGE:**

1. SPECIFIC DRUGS TO WHICH YOU HAVE HAD A REACTION
2. ALL OTHER ALLERGIES
3. ANY PRESCRIPTION DRUG OR HEBAL MEDICATIONS YOU ARE CURRENTLY TAKING

