CANADA PRESCRIPTIONS *plus*

Call Toll-Free: 1-866-779-7587 Fax Toll-Free: 1-877-979-7587

New Patient Mail/Fax Order Form

Fax completed form to:
1–877–979–7587

1. Complete all sections and sign the form.
2. Mail along with your original prescription to: **Suite #551 102-17750 #10 Hwy Surrey, B.C. Canada V3S 1K4**

(You may FAX TOLL-FREE TO: 1–877-979-7587 or EMAIL TO: info@canadaprescriptionsplus.com but we still require your original prescription to be mailed back to us.)

Patient Information (Please Print Clearly)

First Name:_____ Middle Name:_____ Last Name:_____

Your Weight:_____lbs. ❒ Male ❒ Female Birth Date: M_____ D_____ Y_____

Primary Address

Street:_____ City/Town:_____ State:_____

Zip Code:_____ Country:_____

Phone (Home):_____Phone (Work):_____Best Time To Call:_____

Fax:_____Cell:_____Email:_____

Medical History

Please select all that applies to you:

Cholesterol:
- ❒ Stable
- ❒ Unstable
- ❒ Diet Controlled

Diabetes:
- ❒ Type 1
- ❒ Type 2
- ❒ Diet Controlled
- ❒ Insulin

Eye:
- ❒ Glaucoma
- ❒ Macular Degeneration
- ❒ Cataract
- ❒ Ocular Pressures
- ❒ Other: _____

Thyroid:
- ❒ Hormone Therapy
- ❒ TSH
- ❒ HRT
- ❒ Other: _____

Respiratory:
- ❒ Asthma
- ❒ COPD
- ❒ Emphysema
- ❒ Allergies
- ❒ Other: _____

Mood Disorder:
- ❒ Depression
- ❒ Anxiety
- ❒ Psychosis
- ❒ Insomnia
- ❒ Other: _____

Musculoskeletal:
- ❒ Osteoporosis
- ❒ Arthritis
- ❒ Back Pain
- ❒ Autoimmune/Fibromyalgia
- ❒ Other: _____

Cancer:
- ❒ Type: _____

Dermatology:
- ❒ Fungal Infection
- ❒ Psoriasis
- ❒ Rosacea
- ❒ Other: _____

Neurological:
- ❒ Migraine:
- ❒ TIA
- ❒ CVA
- ❒ Neuropathy
- ❒ Parkinsons
- ❒ Dementia
- ❒ Seizures
- ❒ Other: _____

GI:
- ❒ GERD
- ❒ Hiatus Hernia
- ❒ Ulcer
- ❒ IBS
- ❒ Colitis
- ❒ Liver
- ❒ Other: _____

Cardiovascular:
- ❒ High Blood Pressure
- ❒ Angina
- ❒ Heart Failure
- ❒ Heart Attack
- ❒ Arrythmias
- ❒ Heart Surgery
- ❒ Other: _____

Bladder and Kidney:
- ❒ Prostate
- ❒ Other: _____

Other Conditions/Comments:

Drug Allergies:_____

Physician Information

First Name:_____ Last Name:_____

Phone:_____ Fax:_____

Medication Order

Medication Name and Strength	Generic	Rx Required	Quantity
	❒	❒	
	❒	❒	
	❒	❒	
	❒	❒	
	❒	❒	
	❒	❒	
	❒	❒	

Current Medications (Please list all medications taken including over the counter, vitamins, and supplements.)

Medication Name and Strength	Instructions (eg. 1/day)	Time Used (eg. 5 years)	Medical Conditions (eg. high cholesterol)

We require your original prescription, please mail your original prescription to: **Suite #551 102-17750 #10 Hwy Surrey, B.C. Canada V3S 1K4**

Billing Information

First Name:_____ Last Name:_____

Street:_____ City/Town:_____ State:_____

Zip Code:_____ Country:_____

Shipping Information ❑ check if same as billing information

First Name:_____ Last Name:_____

Street:_____ City/Town:_____ State:_____

Zip Code:_____ Country:_____

*Please note, if you order your prescriptions by mail, there is a $9.95 USD shipping fee (additional shipping charges may apply for special shipping requirements) per patient for an unlimited number of prescriptions. All prescriptions will be authorized for a 1-year period if indicated by the physician and will be honoured from the date on the prescription form. Medication shortages happen from time to time. If you have ordered a medication that is on shortage you will be notified prior to shipping. All prescription drug prices include pharmacy dispensing fee.

Payment Method

For added security, a customer service specialist will call to collect credit card information. We proudly accept:

Terms of Agreement

COHI

No prescription(s) will be filled until a signed and dated copy of this document and a completed Patient Profile have been received by Canada Online Healthlink on behalf of Canada Prescription Plus. These documents can be sent by fax to 1-866-732-0306 or mailed to Canada Online Healthlink. Suite #109 - 7938 - 128th Street, Surrey, BC V3W 4E8

Customer Agreement (Part A)

Canada Online Healthlink on behalf of COHI Canada Online Healthlink Inc (as defined below) has established relationships with licensed pharmacies in Canada and licensed pharmacies around the world, which have licensing requirements that are comparable to the ones in Canada. COHI will select the appropriate pharmacy with your consultation to fill your prescription(s) based on product quality, availability and price. If you only want your prescription filled by a licensed Canadian pharmacy, please check this box. ❑

I, as the undersigned, being over the age of 21, hereby:

Disclosure and Representations

Represent and confirm to Canada Online Healthlink, a division of Online Canadian Pharmacy, its affiliates, related companies, and subsidiaries (hereinafter collectively referred to as "COHI") that:

1. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment.
2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician and I will submit original prescrption to you.
3. I will use any medication obtained for me by COHI strictly according to the instructions provided by the physician who prescribed the medication.
4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.
5. I can make my own medical decisions according to the law of the place where I reside.
6. The prescription(s) I am requesting COHI to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to COHI.
7. I am not seeking or relying on any medical information from COHI and I have consulted a qualified physican licensed where I obtained the prescription within the last year.
8. I will immediately contact the physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by COHI.
9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contrindication to me taking the medications being prescribed.
10. I acknowledge that COHI's employees and agents have relied on the information and documentation that I am providing(including the Medical and Medication information) and I represent and confirm that I have fully disclosed all disclosed all pertinent information and documentation to COHI. I agree to notify COHI of any changes to my physical or medical condition by providing an updated patient profile.

Authorization and Consent

11. I hereby authorize and appoint COHI as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf, necessary to obtain a prescription in Canada or elsewhere in the world, which is the equivalent of the prescription that I sent to COHI (the "Equivalent Prescription.") to the same extent that I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to, collecting personal health information about me, collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to COHI employees, agents, affiliates and service providers including without limitation, the physican licensed in Canada or elsewhere in the world and any pharmacy or pharmacist being retained by COHI on my behalf, as required for the limited purpose of obtaining the Equivalent Prescription and filling my order.
12. I hereby specifically acknowledge that I am aware that COHI will be transmitting my personal health information by electronic means (for example: fax and secure Internet) to its employees, agents, affiliates and service providers including the Canadian or global physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that COHI, as a custodian of my personal health information, will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to COHI's transmission of my personal health information by electronic means.
13. If I was directed to COHI's services through an affiliate or intermediary (for example: Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize COHI to release the following data to such an intermediary:
    - **a**. a numerical identifier indicating that I was a patient referred from that source;
    - **b**. financial information that will permit the processing of any claims on my behalf

    It is my understanding that all such intermediaries will enter into will enter into Confidentiality Agreements where they agree to abide by the privacy policies of COHI relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.
14. I authorize and appoint COHI as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.
15. I acknowledge and agree that I initiated a consultation with COHI and that neither COHI nor the COHI Agents are located in the United States. I also acknowledge that the COHI Agents contracted by COHIon my behalf are located in Canada or elsewhere in the world and that all professional services that I receive from the physicians and pharmacists licensed in Canada or elsewhere in the world, as the case may be, are being received in those jurisdictions.
16. I agree that COHI may release my personal health information to the person(s) listed as my "caregiver" in the patient information form.
17. I specifically acknowledge and agree that any and all agreements reached, or contracts formed throughout the course of my purchase of the Pharmaceutical(s) shall be deemed to be made:
    - **a**. in respect of any pharmaceuticals that were dispensed in Canada, in any province of Canada, and accordingly shall be goverend by the laws of the appropriate province and the laws of Canada applicable to such contracts and agreemnts; and
    - **b**. in respect of any pharmaceuticals that are dispensed elsewhere in the world, according to the local laws applicable to such contracts and agree
18. I specifically acknowledge that title to all products ordered through COHI pass to me and I become owner of the products when the fulfillment pharmacy places the products in a container or otherwise completes the steps necessary to prepare the product for my use.
19. I specifically acknowledge and agree that any dispute that arises between me and COHI or any of the COHI Agents
    - **a**. shall be governed by the laws of the Province of British Columbia and the laws of Canada applicable to contracts formed in British Columbia, and that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such disputes;

Purchase and Sale Terms

20. COHI will charge my credit card for the following amounts:
    - **a**. The medication price plus shipping and handling as posted on the COHI website on the day COHI receives my order; and
    - **b**. In the event my payment is not authorized, COHI has the right to cancel my order and attempt to provide me with notice of such cancellation.
21. The pharmaceutical(s) will be packaged, as per my request in the Medication Order form.
22. COHI shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless the physician has indicated that there be "no substitution" or "dispensed as written". That once purchased and shipped, no pharmaceutical product may be returned or exchanged.
23. COHI reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund of monies paid for such order.
24. COHI does not provide its agency or attorney services as a substitute for healthcare of the advice of the customer's primary care physician.
25. COHI will not exchange medication or return any monies paid once an order is shipped, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.
26. I specifically acknowledge and agree that each and every one of these terms and condition will automatically and without further action by me or COHI, apply to and govern any future orders by me of pharmaceutical(s) from COHI unless I specifically indicate otherwise at the time of ordering such pharmaceutical(s). Without limiting the foregoing, each authorization and consent provided by me in this Agreement shall continue until I revoke such authorization or consent (which I can do at any time).

I have read and understood the terms and conditions set out in the Agreement and agree, on behalf of myself, my heirs, successors, executors, administrators and assigns, to be bound by these terms and conditions.

Signed this _____ day of _____, 20___

_____ _____

Signature (Print Name)