

Reorder Form



Prescriptnet, #210 - 19 Dallas Road
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Visit Prescriptnet on the Web: www.prescriptnet.com

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PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING INFORMATION.

It is mandatory that you have completed a physical examination in the past 12 months. Have you? Yes No

<i>Personal Information</i>			
Last Name	First Name	Gender (M/F)	
Height	Weight	Date of Birth YYYY/MM/DD	
Address	City	State	Zip
Mailing Address (if different)	City	State	Zip
Telephone	Alternate Telephone	E-mail	
When would be a convenient time for the pharmacist to call you? Best time to call: _____	Has there been any change to your Health Profile/Drugs since your last order? <input type="checkbox"/> YES (Complete and attach the Health Questionnaire) <input type="checkbox"/> NO	How can we help you? Please check below: <input type="checkbox"/> Refill (I have an existing prescription on file) <input type="checkbox"/> New Prescription (I am submitting a new prescription from my doctor.)	

<i>Medication Order</i>					
SOURCE COUNTRY	BRAND NAME	GENERIC NAME (IF KNOWN)	STRENGTH	QUANTITY	PRICE (USD)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
SHIPPING: Prescriptnet ships your medication within 24 hours of order completion. Postal delivery of orders to your destination can take between 5 and 30 days, so we recommend placing your order at least 30 days before your current supply of medications will be exhausted. Please remember Prescriptnet cannot make a point-to-point investigation of any shipment until 30 days after the shipping date.			Free shipping from US <input type="checkbox"/> \$9.95 - Shipping from Canada <input type="checkbox"/> \$9.95 - Shipping from UK Shipping costs are cumulative	SUB-TOTAL _____ SHIPPING _____ TOTAL _____	

<i>Payment Information</i>	
<input type="checkbox"/> Visa	_____
<input type="checkbox"/> MasterCard	_____
Cardholder Name (first)	(last)
Credit Card Number	Expiry MM/YY
Authorized Signature	Authorization Number

By submitting this form, you agree that the above order will be fulfilled and mailed to you and that you cannot return these medications for any reason as per the College Bylaws. All Sales are final.

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Personal Information

Last Name	First Name	Gender (M/F)	Date of Birth
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YYYY/MM/DD

Medical History (Please complete the following information for our physician and pharmacist.)

 Do you have any known drug allergies? YES NO

 If yes, please list the drugs you are allergic to: _____

Date of last reaction (i.e. November 1997) _____

Have your drug allergies ever resulted in:

 skin rash (spots, redness, itchiness) YES NO

 breathing problems, wheezing or coughing YES NO

 sudden drop in blood pressure YES NO

 Do you smoke? YES NO

 Have you ever smoked? YES NO

When did you last smoke? (i.e. 1980) _____

Do any of the following conditions apply to the state of your health. If yes, please check.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Disorder / Ulcer |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Disease / Disorder |
| <input type="checkbox"/> Aneurysm / Embolism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malnutrition | List any medications you are |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fluid Retention | <input type="checkbox"/> Melanoma / Skin Cancer | currently taking: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | _____ |
| <input type="checkbox"/> Blood Disorder(s) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ovarian Cancer | _____ |
| <input type="checkbox"/> Bone / Joint Disorder(s) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease | _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Cancer | _____ |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Kidney Disorder(s) | <input type="checkbox"/> Rheumatoid Arthritis | _____ |

Please complete the following information about your prescribing physician

Physician Information

Last Name	First Name
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Address	City	State	Zip
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Telephone	Fax	E-mail (if known)
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