

# Order Form

## PERSONAL INFORMATION

**Full Name** \_\_\_\_\_  
(please print clearly)

**Birth date (MM/DD/YY)** \_\_\_\_\_  Male  Female

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Country** \_\_\_\_\_ **ZIP Code** \_\_\_\_\_

**Phone (Home)** \_\_\_\_\_ **Phone (Other)** \_\_\_\_\_

**Email** \_\_\_\_\_

**Best time to be contacted** \_\_\_\_\_

**Please check if you are placing this order for a pet.**  
 Cat  Dog  Other \_\_\_\_\_  
(Please specify)

## MEDICATIONS TO ORDER

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

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
<b>SUB TOTAL:</b>				
<b>SHIPPING:</b>				<b>\$9.99</b>
<b>TOTAL:</b>				

## PAYMENT OPTIONS

**Pay by Credit Card**    

**Please call me to obtain my credit card information**


Please note that in order to comply with the Payment Card Industry (PCI) Security Standard Council's requirements for the protection of your credit card information we are only able to accept your credit card information via telephone or through our secure online ordering system.

### Personal Checking Account (Check or EFT) USA Only

**Use my check information "on file"**

**I will send a VOIDED check**

**By:**  Fax  Email

**I will make a payment by check, and mail it to** 

Mailing Address:

Global Care Rx  
78 Pleasant Blvd  
Suite 1083  
Toronto, Ontario  
Canada M4T 1K2

## FIRST TIME PATIENTS

(Please fill out this section if you are a first time patient, or to update your information.)

### Your Physician

**Primary Physician's Name** \_\_\_\_\_

**Clinic Name** \_\_\_\_\_ **Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Country** \_\_\_\_\_ **ZIP Code** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Ext.** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

## ALLERGIES

**Do you have any known drug allergies?**  Yes  No

**If yes, please enter the drug(s) you are allergic to:** \_\_\_\_\_  
\_\_\_\_\_

## PRESCRIPTION SUBMISSION

(Please select one of the three options below.)

**Option 1. Call My Doctor**

**Primary Physician's Name** \_\_\_\_\_

**Clinic Name** \_\_\_\_\_ **Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Country** \_\_\_\_\_ **ZIP Code** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Ext.** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

**Option 2. Transfer from another pharmacy**

**Pharmacy Name** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Country** \_\_\_\_\_ **ZIP Code** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Ext.** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

**Option 3. Mail or Fax Your Prescriptions**

Fax To:  
1-888-886-5803

Mail To:  
Global Care Rx, 78 Pleasant Blvd, Suite 1083  
Toronto, Ontario, Canada M4T 1K2

## Medication, OTC, Herbal Products You Are Currently Taking

(Only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY