Global Care Rx

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

Toll Free Phone: 1-888-487-3440
Toll Free Fax: 1-888-886-5803
Email: info@globalcarerx.com
Website: www.globalcarerx.com

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
			SUB TOTAL:	
			SHIPPING:	**$9.99**
			TOTAL:	

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