CANADIAN DISCOUNT RX SERVICES

PHONE 352-347-0403 // FAX 352-347-2034

CONTACT INFORMATION **DATE** / /

Name: _____Date of Birth: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____CellPhone:_____Email:_____

Sex:_____ Height: _____ Weight: _____ Drug Allergies: _____,_____,_____

REQUESTED MEDICATION	BRAND/GENERIC	DOSAGE	QUANTITY	PRICE
1._____	_____	_____	_____	$_____
2._____	_____	_____	_____	$_____
3._____	_____	_____	_____	$_____

PRESCRIBING PHYSICIAN'S NAME: _____

PLEASE NOTE: It is mandatory to have had a physician's examination in the last 12 months. Date of examination: _____

Please list all medications you are currently using, including the dosage and frequency.

MEDICATION NAME	STRENGTH/DOSAGE	DIRECTION FOR USE

Your Personal Medical History:

BLOOD DISORDERS	YES	NO	ORTHOPEDIC OR MUSCLE DISEASE	YES	NO
CANCER	YES	NO	MENTAL DISORDERS	YES	NO
IMMUNE DISORDERS	YES	NO	SURGICAL PROCEDURES	YES	NO
POOR WOUND HEALING	YES	NO	GLAUCOMA	YES	NO
NEUROLOGICAL DISORDERS	YES	NO	ADDICTIONS-CHEMICAL	YES	NO
HORMONE DISORDERS	YES	NO	AIRWAY DISEASE	YES	NO
NUTRITIONAL, MINERAL, ELECTROLYTE IMBALANCE	YES	NO	SMOKER	YES	NO
LIPID/CHOLESTEROL DISORDER	YES	NO	LUNG DISEASE	YES	NO
HEART/CIRCULATION DISEASE	YES	NO	ARTHRITIS, LUPUS	YES	NO
DIABETES	YES	NO			
KIDNEY/URINARY DISEASE	YES	NO	HIGH BLOOD PRESSURE	YES	NO
LIVER DISEASE	YES	NO	OTHER CONDITIONS (LIST BELOW)	YES	NO

I Certify that the information provided is complete and accurate: Signature : _____Date_____

BILLING INFORMATION: (Please note - no credit cards accepted) :

MONEY ORDER_____ CHECK _____ (Make Checks and Money Orders payable to: CDSH Enterprises)

CANADIAN DISCOUNT RX SERVICES
USER AGREEMENT FORM

No prescription will be filled without a signed and dated copy of the form.
The undersigned, (hereinafter the Patient) confirms that:

1. The Patient is of the age of majority in the jurisdiction, in which the patient resides and is full competent to make their own health care decisions.

2. The Patient confirms that the pharmaceutical(s) ordered by the Patient ("the ordered product") were prescribed by a duly qualified medical practitioner in the place of residence of the Patient. The Patient had not violated any laws in obtaining the prescription and that the Ordered Product will not be used by no other person and in no manner except as prescribed by the original prescribing physician ("The Patient's Physician").

3. The Patient agrees to direct all questions to The Patient's Physician. The Patient will consult the Patient's Physician before taking any new drug, natural product, or changing their daily health regiment.

4. The dispensing Pharmacy requires the patient to submit a new medical questionnaire every time there is a change to their medical status. The Patient understands that it is their responsibility to have the Patient's Physician conduct regular physical examinations (minimum every 12 months), including any and all suggested testing by the Patient's Physician to ensure that they have no medical problems which would constitute a contradiction to them taking medications prescribed for them. The Patient agrees that should they suffer any adverse effects while taking any prescription medication that they will immediately contact the Patient's Physician and that in the event they come under the care of another physician, the Patient will inform this physician of any and all medications that have been prescribes.

5. The Patient must take responsibility to secure their own medication stock from a local pharmacy in the interim if such an event was to evolve, ensuring that at no point they are without medication.

6. The Patient grants Limited Power of Attorney to Dispensing Pharmacy, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Ordered Product to the Patient, in the same manner as the Patient could, if the Patient had personally attended the pharmacy in Winnipeg, Manitoba, Canada.

7. The Patient agrees that any dispute that arises between Him or Her and Dispensing Pharmacy shall be heard by the courts of Manitoba, Canada. The courts of Manitoba, Canada shall have the sole and exclusive jurisdiction, and that the laws in force in Manitoba, Canada, shall apply to any and all disputed that may arise.

8. The Patient must honestly report all requested and immediately update any changes to his or her record.

9. RETURN POLICY: Neither we, nor Canadian pharmacies can accept returns. Canadian law states – "The pharmacist shall not accept the return for use or re-use of any portion of any drug or non-prescription medication (College of Pharmacist Standard 5.1 (m) Standards of Practice-The Pharmacist, Jan. 1, 1996."

BY SIGNING THIS DOCUMENT THE PATIENT CONFIRMS THAT HE OR SHE HAS READ AND UNDERSTOOD EACH OF THE ABOVE TERMS AND HAS AGREED TO EACH ONE.The authorizations within this customer agreement shall continue until revoked.

Print Name: _____

Patient Signature: _____ Date: _____

Please help us serve others better. How did you hear about us? Please check all that applies:
_____ Newspaper Ad
_____ Friend
_____ Physician
_____ Other (please specify) _____