

# CanadaGeneric Medical Order Form

Fax Toll Free 1-888-337-0566

Name: .....

Date: .....

Date of Birth (mm/dd/yy): .....

Phone # ( ..... ) .....

Mailing Address: .....

Apt: .....

City: .....

State: ..... Zip Code: .....

Height: ..... Weight: .....

Gender: \_\_\_ Male \_\_\_ Female

Email Address (if available): .....

Is this your first order with Canadageneric? \_\_\_ Yes \_\_\_ No

Requested Medication	Dosage/Quantity	Condition	New Medication? (Y/N)	Price
			Shipping:	<b>\$9.99</b>
			<b>Total Enclosed:</b>	

**Please List Any Known Drug Allergies:**

.....

**List Any Other Medications You Are Currently Taking And the Medical Condition They Are For:**

Medication..... Reason.....

Medication..... Reason.....

Medication..... Reason.....

Medication..... Reason.....

**Patient Counselling:**

Do you require pharmacist consultation? \_\_\_ Yes \_\_\_ No

Do you require easy open caps? \_\_\_ Yes \_\_\_ No

**Doctor's Information**

First Name..... Last Name.....

Phone # ( ..... ) ..... Fax # ( ..... ) ..... Address: .....

City: ..... State: ..... Zip Code: .....

**Pay by Cheque:**

If you wish to pay by cheque, please make payment to **CanadaGeneric.com**.

**Pay by Credit Card:**

Card Type: \_\_\_ Visa \_\_\_ MasterCard

Name on Card:..... Credit Card #.....

Card Expiry Date (mm/yy):..... CW2 Code\*..... Signature:..... Date(dd/mm/yy):.....

\*The CW2 code is the last 3 digits printed on the signature strip on the back of your card. If you are unclear or do not know the number, please leave blank.