Patient Information

Affiliate

Form #1

License #32599

Toll Free Phone 1-800-640-2221
Toll Free Fax 1-800-640-5553
www.cantrustrx.com

#1- 733 Pembina Hwy
Winnipeg, MB
Canada R3L 0K5

Complete this form and fax or mail it along with:
1) Original Prescription 2) Medication Order Form 3) Release Form
The Patient Information Form and Release form only need to be submitted with first order.

First Name:_____________________________ Last Name:____________________________________
Address: ____
City:___________________________ State:__________________ Zip Code:__________________
Home Phone:(   )_______________ Work/Day Phone:(   )__________________
Fax: (   )___________________ E-mail____
Date of Birth: / / (mm/dd/yy) Weight: _________ Sex: o male o female

Secondary Contact: __________________________________Phone: (   )_____________________
Relationship:______________________________

Your Doctor's Information:
Name:________________________ Address:_______________________________________
Phone: (   )___________________ City, State: __________________________________

Known Drug Allergies:

Medication	*Reaction*

Current Medications:
Please list all medications you are currently using.

Drug Name	Strength	Directions	How long using	Drug is used to treat
Example drug	5mg	1 tablet twice a day	2 years	diabetes
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Patient Signature:______________________________Date:__________________

Referred by:_______________________________________Address:______________________________

Patient Information Form #2

Affiliate

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Please answer the following questions by circling Yes or No

Question		
1. We will provide your order with child resistant containers unless you request otherwise. Do you require your medication to be shipped in child proof containers?	**Yes**	**No**
2. Some drug manufacturers prepackage medication in blister packaging. Do you require us to transfer those medications to a Child Proof Container?	**Yes**	**No**
3. It is mandatory to have had a physical exam in the last 12 months. Have you had one?	**Yes**	**No**
4. Will you accept a generic version of the drug ordered to save more money?	**Yes**	**No**

Personal Medical History:

Condition			Condition		
1) Cancer	**Y**	**N**	15) Liver disease	**Y**	**N**
2) Immune disorders	**Y**	**N**	16) Anxiety	**Y**	**N**
3) Poor wound healing	**Y**	**N**	17) Depression	**Y**	**N**
4) Lung disorders (Asthma,COPD,Emphysema)	**Y**	**N**	18) Other emotional disorders	**Y**	**N**
5) Upper respiratory disorders	**Y**	**N**	19) Parkinsons	**Y**	**N**
6) Smoker	**Y**	**N**	20) Epilepsy	**Y**	**N**
7) High blood pressure	**Y**	**N**	21) Schizophrenia	**Y**	**N**
8) Heart disease (incl. Arteriosclorosis, angina, heart failure, or history of heart attack)	**Y**	**N**	22) Other neurological disorders	**Y**	**N**
			23) Thyroid disorder	**Y**	**N**
9) Hyperlipidemia (high cholesterol)	**Y**	**N**	24) Diabetes	**Y**	**N**
10) Glaucoma	**Y**	**N**	25) Other endocrine disorders	**Y**	**N**
11) Known nutritional deficiency (incl. Minerals or electrolytes)	**Y**	**N**	26) Recent surgery	**Y**	**N**
			27) Past surgery	**Y**	**N**
12) Chemical dependency	**Y**	**N**	28) Renal or kidney disease	**Y**	**N**
13) Rheumatoid Arthritis, Lupus, or connective tissue diseases	**Y**	**N**	29) Blood disorders	**Y**	**N**
			30) Other illness not listed above	**Y**	**N**
14) Orthopedic or muscle disorder (incl. fracture, joint disorder, or Carpal tunnel syndrome)	**Y**	**N**			

If you answered yes to any of the above questions, please explain further:

Patient Signature:________________________________ Date:__________________

Medication Order

Affiliate

Form #3

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Winnipeg, MB
Canada R3L 0K5

Complete this form and fax or mail it along with:
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Drug Name	Strength	Directions	Quantity	Price
Example drug	10mg	1 tablet 3 times a day	300	$00.00
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Shipping and Handling: There will be a $14.00 shipping fee per household				**$14.00**
Total (all amounts are in US dollars)				

Billing Information:
Please input the EXACT credit card billing information, or your order will be delayed.

Type of card: Visa O Mastercard O American Express O
Cardholder's Name: ____
Credit Card Number: _________________________________Expiry Date:_____/_____
Address to send receipt to:____
____

As a member of the Manitoba Pharmaceutical Association, we pledge to keep all of our clients well informed about the prescription medications we provide. We also ensure that these consultations will be conducted in an atmosphere of confidentiality and privacy. These consultations are designed to provide you, our clients, with important information regarding your prescription medications. This information includes:

- ? The drug name
- ? What to do if a dose is missed
- ? The importance of taking the drug as directed, regularly or when needed
- ? Food, drink, other drugs or activities to avoid
- ? What the drug does
- ? Common side effects
- ? How and at what time the drug should be taken
- ? Refill information
- ? Special storage requirements

A reminder to please consult your doctor or pharmacist before taking any medication not prescribed by your doctor.

To confirm that you have read the above, please sign and date below:

Patient signature:___________________________________ Date:_________________

CanTrustRx Inc. Limited Power of Attorney & Release Form

No prescription will be filled until a signed and dated copy of this document and a completed Patient Questionnaire has been received by CanTrustRx Inc. These documents can sent be fax toll free to [1-800-640-5553]

THE UNDERSIGNED, BEING OVER THE AGE OF 21, HEREBY:

1. Represents and confirms CanTrustRx Inc., along with its subsidiaries and affiliates (herein collectively "CanTrust") that the pharmaceutical(s) to be delivered to the undersigned were prescribed by a doctor licensed to practice medicine in the country, state, or other applicable jurisdiction in which the undersigned resides, that the prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician and that the pharmaceutical(s) will be used only as directed and only by the person for whom the pharmaceutical was prescribed.
2. Acknowledges that CanTrust and CanTrust's employees and agents have relied on the information and documentation provided by the undersigned (including the Patient Questionnaire) and the undersigned represents and confirms that the undersigned has, to the best of his/her knowledge, fully disclosed all pertinent requested information and documentation to CanTrust. The undersigned undertakes to notify CanTrust of any changes to his/her physical or medical condition by providing an updated Patient Questionnaire.
3. Understands that it is the undersigned's responsibility to have regular physical examinations by the U.S. licensed physician whose care he/she is under, including all suggested testing by said physician to ensure the undersigned has no medical problems, which would constitute a contradiction to him/her taking the medication(s) being prescribed.
4. Authorizes and appoints CanTrust, as his/her agent and his/her attorney for the limited purposes of taking all steps and signing all documents on behalf of the undersigned necessary to obtain a prescription in Canada for the prescription sent by the undersigned to CanTrust, to the same extent as the undersigned could do if he/she were personally present taking those steps and signing those documents himself/herself, including, but not limited to, collecting personal health information regarding the undersigned directly from his/her prescribing physician or pharmacist and disclosing personal health information to CanTrust employees, agents and service providers, as required, for the limited purposes set out above.
5. Authorizes and appoints CanTrust as his/her agent and his/her attorney for the purpose of taking all steps and signing all documents on behalf of the undersigned necessary to package or repackage the pharmaceutical(s) and to deliver them to the undersigned, to the same extent as the undersigned could do if he/she were personally present taking those steps and signing those documents himself/herself.
6. Authorizes and appoints CanTrust, as his/her agent and as his/her attorney for the purpose of taking all steps and signing all documents on behalf of the undersigned for shipping his/her prescribed pharmaceutical(s) to the undersigned as if the undersigned had shipped the prescribed pharmaceutical(s) to himself/herself to the undersigned's address.
7. Acknowledges and agrees that the undersigned initiated a consultation with CanTrust and that CanTrust is not located in the United States. The undersigned acknowledges that the pharmacists working for CanTrust and the physicians contracted by CanTrust on the undersigned's behalf are located and licensed to practice medicine or pharmacy in Canada and that all treatment the undersigned is receiving from the said physician and pharmacist is being received in Canada. 8
8. Acknowledges and agrees that any and all agreements reached or contracts formed throughout the course of the relationship between the undersigned and CanTrust shall be deemed to be made in Manitoba, and accordingly shall be governed by the laws of the Province of Manitoba and the laws of Canada as applicable to such contracts and agreements. 99
9. Agrees that any dispute that arises between him/her and CanTrust, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees or agents shall be governed by the laws of the Province of Manitoba and the laws of Canada applicable to contracts formed in Manitoba and the undersigned agrees that the Courts of the Province of Manitoba shall have sole and exclusive jurisdiction over any such dispute. 1
10. Understands that CanTrust shall be entitled to substitute a prescription drug with a generic drug, where available in accordance with the Manitoba Drug Standards and Therapeutics Formulary, unless the physician has indicated that there be "no substitution". 11
11. Acknowledges and understands that once purchased and shipped, no pharmaceutical product may be returned or exchanged.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THESE TERMS AND AGREES THAT THEY SHALL BE BINDING UPON THE UNDERSIGNED AND HIS/HER HEIRS, SUCCESSORS AND PERSONAL REPRESENTATIVES

Patient Signature: ____

Print Patient Name: ____

Date Signed: ____