

# CanadaDrugPharmacy.com

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www.CanadaDrugPharmacy.com

## New Prescription & Refill Order Form

| Patient Information  |  |                                 |  | WB-CDP               |                |
|--|--|---------------------------------|--|----------------------|----------------|
| First Name:  |  | Last Name:                      |  |                      |                |
| Telephone Number:<br>(     )   |  | Secondary Telephone:<br>(     ) |  |                      |                |
| Shipping Address: (Street & Apt. #) – if different from above  |  |                                 |  |                      |                |
| City:  |  | State:                          |  | ZIP:                 |                |
| Have there been any changes to your <b>health</b> <u>OR</u> <b>medications</b> being taken (i.e. changes in strengths or quantities) since placing your last order? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                 |  |                      |                |
| <b>If <u>YES</u> to the above</b> , please describe in detail any changes below:   |  |                                 |  |                      |                |
| <b>Medications Being Refilled</b>  |  |                                 |  |                      |                |
| Drug Name  |  | Strength                        | Quantity                               | Generics<br>(Y or N) | Price<br>(USD) |
| 1.   |  |                                 |  |                      |                |
| 2.   |  |                                 |  |                      |                |
| 3.   |  |                                 |  |                      |                |
| 4.   |  |                                 |  |                      |                |
| 5.   |  |                                 |  |                      |                |
| 6.   |  |                                 |  |                      |                |
| 7.   |  |                                 |  |                      |                |
| 8.   |  |                                 |  |                      |                |
| Shipping and handling fees are \$10.00 per package, not per prescription.  |  |                                 |  | <b>Shipping</b>      |                |
|  |  |                                 |  | <b>Total</b>         |                |
| Has your billing information changed since your last order? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |                                 |  |                      |                |
| <b>If <u>YES</u> to the above</b> , please complete the following:   |  |                                 |  |                      |                |
| *How would you like to pay for your medications? (Check one only)  |  |                                 |  |                      |                |
| <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> Money Order   |  |                                 |  |                      |                |
| ** Please make all money orders and bank drafts payable to: <b>GLOBAL HEALTH SUPPLIES</b> **   |  |                                 |  |                      |                |
| *Name on Credit Card:  |  |                                 | *Credit Card Number:                   |                      |                |
| *Credit Card Verification Number: (The verification number is a 3-digit number printed on the back of your card. It appears after and to the right of your card number on the signature field.)                              |  |                                 | *Card Expiry Date: ____ / ____ (mm/yy) |                      |                |
| <b>Fax to 1-877-295-8222 for Processing</b>  |  |                                 |  |                      |                |