Canpharm Medical Order Form

Fax Toll Free 1-800-501-5431

Name: _____ Date: _____

Date of Birth (dd/mm/yy): _____ Phone # (_____)_____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Height: _____ Weight: _____ Gender: ___Male ___Female

Email Address (if available): _____

Is this your first order with Canpharm? ___Yes ___No Referred by (Name): _____

Requested Medication	Condition	Dosage/Quantity	New Medication? (Y/N)	Price
			Shipping:	
			Total Enclosed:	

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 Counseling:

Do you require pharmacist consultation? ___Yes ___ No

Do you require easy open caps? ___Yes ___ No

Payment Method: ___MasterCard ___Visa

Name on Card:_____ Credit Card #_____

Exp(mm/yy):_____ CVV2 Code*_____ Signature:_____ Date(dd/mm/yy):_____

*The CVV2 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.