

Patient Form

Thank you for your interest in our prescription service. Customers can save from 20 - 85% on the cost of their medications by getting their prescriptions filled in Canada. Our prescription service allows customers to access the same medications that are available to them locally, but at much lower Canadian Prices.

If you need any information regarding the price of your prescription please contact us toll-free at 1.877.828.7555.

Ordering Your Prescription:

- **Step 1:**
Please complete the following medical questionnaire/medication order form. Any information you provide will be kept strictly confidential. You will only have to fill out this order form the first time you order from us.
- **Step 2:**
Simply mail the information back to us, or to save mailing time, fax it toll-free to 1-866-783-4223.
Mail to: Senior Rx Care
PO Box 2581, Stn. Main 266 Graham
Winnipeg, Manitoba, Canada
R3C 4B3
- **Payment:**
We accept VISA, MasterCard, checks and international money orders made out to Universal Drugstore Ltd. There is a short waiting period for banking authorization on personal checks.
- **Shipping:**
The shipping fee is a flat rate of \$10.00 per package (not per drug, but per shipment) within the continental US.

Please Be Advised:

- Government regulations limit the quantity of medication that you can order to a maximum of a 3-month supply. If your prescription allows refills, you can simply call us to order your refill.
- Most insurance companies will accept receipts issued from a Canadian pharmacy, however, patients with drug insurance plans should contact their insurance company first before ordering.
- Our service is open to anyone who is a member of The Coalition of Wisconsin Aging Groups. Please feel free to give our toll-free number or website address to friends and family, or to make copies of our order form for other people.
- On occasion, shipping delays can occur as a result of action by US customs and the US FDA. They can hold shipments for up to 30 days. Such delays are beyond our control. Please ensure you have enough medication on hand for possible delays.

Contact Us:

Toll-Free Phone: 1-877-828-7555
Toll-Free Fax: 1-866-783-4223
Email: info@seniorrxcare.com



Patient Information

Male
 Female

Patient Name _____ Birthdate (MM/DD/YY) ____/____/____

Shipping Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____

Email Address _____

Secondary Contact

Full Name of Secondary Contact _____

Relationship To You _____ Phone Number _____

Your Physician

Primary Physician's Name _____

Phone Number _____ Ext. _____ Fax Number _____

Medication Being Ordered (Attach additional sheet if required)

Important (Please read carefully): In the spaces provided below please write the medications that you would like us to fill for you at this time. Any medications not written here, but which you have sent a prescription for, will not be filled at this time. These medications will be filed on our computer and can be filled at a later date.

| Brand Only | Generics Permitted | Requested Medications | Strength | QTY | Price |
|-----------------------|-----------------------|-----------------------|----------|-----|-------|
| <input type="radio"/> | <input type="radio"/> | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | |

Please note that we will fill your prescription where applicable in the manufacturer's sealed containers. For example, if your prescription calls for 90 tablets, but the manufacturer supplies bottles of 100, we will fill for 100 tablets.

| | |
|---------------------------------------------------------------------------------------|----------------|
| Add \$10.00 Shipping & Handling to U.S. (Trackable Insured Shipping via Express Post) | \$10.00 |
| (Payment in U.S. Funds) Total Enclosed | |

Current Medications

This is for our records only and will be kept confidential. Listing other medications that you are currently taking will help us create a more complete medical history for you.

Please enter any known drug allergies.

Drug Info

Please choose one of the following 3 options

A pharmacist may contact you with any questions regarding your medication

- I understand my medications and do not need to speak to a pharmacist or receive information sheets.
- I do require medication information sheet only.
- I would like to speak to a pharmacist about my medications.

If you require drug info as indicated above, how would you like to be contacted?

Telephone: _____

Fax: _____

Email Address: _____



Patient's Name (Please Print)

Phone Number

Patient's Signature

Date

• YOUR PRESCRIPTIONS – Attach Here

(Please ensure that we can see the entire prescription)
Please use additional pieces of paper if you cannot fit all
of your prescriptions in the designated area