

Direct Prescription Service

942 Aldgate Rd., Winnipeg, MB, R2N4P5 Canada toll free: 866-220-3551, fax: 888-589-1743, Email: pharmacyorder@shaw.ca

PRESCRIPTION REQUEST FORM Wabash Memorial Hospital Association

First Name: _____	Last Name: _____
Address: _____	E mail: _____
City: _____	State: _____ Zip Code: _____
Phone: _____ Fax: _____	D.O.B / / (mm/dd/yyyy)

MY PRIMARY PHYSICIAN

Doctor's Name: _____	Phone: _____
Address: _____	City/Town: _____
State: _____	Zip Code: _____ Fax: _____

PRESCRIPTION REQUEST FORM

Prescription number (Found top left hand corner: Rx#)	Medication Name	Dosage	Quantity
1)			
2)			
3)			

Medication, OTC, Herbal Products You Are Currently Taking

Medication	Dosage	Frequency
1).		
2).		
3.)		

Payment options

Type of card: Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> 3 digit code _____ Expiration Date: _____
Cardholder's Name: _____ Address to send receipt to: if different from above: _____
Credit Card Number: _____

Patient Authorization (Please Check One)

Direct Prescription Service operates a marketing call center business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales between Direct Prescription Service authorized dispensary (the "pharmacy") and the individual (the "patient")

Regarding the products and services (the "products") offered for sale by the pharmacy. The patient herein represents to the pharmacy that:

I am over the age of majority, and

1. I have fully and accurately disclosed my personal information and consent to its use by the pharmacy. I have had a full physical exam within the last 12 months and do not require a physical exam.
2. I understand that all products shall be sold and dispensed by a pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
3. I authorize and appoint the pharmacy as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription I have sent to the pharmacy, and (b) packaging my prescriptions and delivering them to me. This authorization shall include but not be limited to: collecting and using my personal health information (PHI) as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.
4. I understand that the pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the pharmacy. Title to my medication passes from the pharmacy to me in the jurisdiction of the pharmacy when my medications leave the pharmacy. All agreements reached or contracts formed with the pharmacy shall be deemed to be made in the jurisdiction of the pharmacy, the laws of the jurisdiction of the pharmacy shall govern all the transactions, and I attorn to the courts of the jurisdiction of the pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the pharmacy, its affiliates, officers and directors.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS, AND PERSONAL REPRESENTATIVES.

OR:

"I am the parent/legal guardian/power of attorney for the patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representation to the pharmacy on the patients behalf."

Patient Signature: _____
Date Signed: ____/____/____

Print Patient Name: _____