

**Form 1 Wabash Memorial Hospital Association Affiliate #**

**MY PERSONAL INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ (mm/dd/yy) Weight (lbs): \_\_\_\_\_  
 Secondary Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
**Email :** \_\_\_\_\_

**MY PRIMARY PHYSICIAN**

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Town: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

**MY CURRENT MEDICATIONS**

These are the medications that have been prescribed to me to treat the following conditions:

| Medication | How long | Condition (if known) |
|------------|----------|----------------------|
| 1.         |          |                      |
| 2.         |          |                      |
| 3.         |          |                      |
| 4.         |          |                      |
| 5.         |          |                      |
| 6.         |          |                      |
| 7.         |          |                      |
| 8.         |          |                      |

Please answer the following questions by circling **Yes** or **No**:

We do not usually ship medications in Child Proof Containers. If you require Child Proof Containers, please indicate by checking the box. Yes      No

It is mandatory to have had a physical examination in the last 12 months. Have you had one? Yes      No

Will you accept a generic version of the drug ordered to save more money? Yes      No

Patient Signature: \_\_\_\_\_  
 Print Patient Name: \_\_\_\_\_  
 Date Signed: \_\_\_\_\_

*“Caring for others as we would want to be cared for”*

*Fax or mail your completed forms*

**Form 2                      Wabash Memorial Hospital Association    Affiliate #**

**MY PERSONAL MEDICAL HISTORY**

\* I have been diagnosed or treated for the following conditions:

| Medical Condition   | No | Yes | Description |
|---|----|-----|-------------|
| <b>Drug Allergies</b>   |    |     |             |
| Cancer  |    |     |             |
| Immune Disorders  |    |     |             |
| Poor wound healing  |    |     |             |
| Neurological disorders  |    |     |             |
| Diabetes, thyroid or other endocrine disorders  |    |     |             |
| Known nutrition deficiency including minerals or electrolytes                               |    |     |             |
| Lipid or cholesterol disorder   |    |     |             |
| Heart disease including arteriosclerosis, angina, heart failure or history or heart attack  |    |     |             |
| Renal or kidney disease   |    |     |             |
| Liver disease   |    |     |             |
| Blood Disorders   |    |     |             |
| Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome |    |     |             |
| Emotional disorders   |    |     |             |
| Surgery   |    |     |             |
| Glaucoma  |    |     |             |
| Hyperlipidemia (high cholesterol)   |    |     |             |
| Chemical dependency   |    |     |             |
| Upper respiratory disorders   |    |     |             |
| Smoker  |    |     |             |
| Lung disorder (i.e. asthma, emphysema)  |    |     |             |
| Rheumatoid arthritis, lupus, or connective tissue diseases                                  |    |     |             |
| High blood pressure   |    |     |             |
| Other illness not listed above  |    |     |             |

**Patient Signature:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

*Fax or mail your completed forms*

**Form 3 Wabash Memorial Hospital Association Affiliate #**

**PRESCRIPTION REQUEST FORM**

| Medication | Strength | Dose | Quantity | Price |
|------------|----------|------|----------|-------|
| 1.         |          |      |          |       |
| 2.         |          |      |          |       |
| 3.         |          |      |          |       |
| 4.         |          |      |          |       |
| 5.         |          |      |          |       |
| 6.         |          |      |          |       |
| 7.         |          |      |          |       |
| 8.         |          |      |          |       |

**Shipping and Handling: There will be a \$14.00 shipping fee unlimited medications per household ordered at the same time**

**TOTAL (all amounts are in US dollars)**

**MY BILLING INFORMATION**

Please input the *EXACT* credit card/account, or your order *will be delayed*.

Method of Payment:     Visa \_\_\_    MasterCard \_\_\_    American Express \_\_\_

Accountholder's Name: \_\_\_\_\_

Credit Card/Account Number: \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_

\*\*\* Please note American Express charges will be billed in Canadian funds. All MasterCard and Visa charges will be placed in American funds. If you are paying by check or money order, all checks must be certified, and all money orders must be international. If you have any questions regarding method of payment, please contact CanTrustRx Inc. Thank you

Do you have any questions about your medications that you would like our pharmacist to talk to you about since your last refill?     Please circle:                    Yes            No

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

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

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

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Fax or mail your completed forms*

# Form 4 Wabash Memorial Hospital Association

Affiliate #

## 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.

**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 repack 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. Understands and acknowledges that the pharmaceutical(s) will not be packaged in child protective packaging, unless requested by the undersigned on the Patient Questionnaire, and the undersigned releases and discharges CanTrust and CanTrust's employees and agents, from any and all causes of action with respect to the late delivery, non-delivery or missed delivery of the pharmaceutical(s) sent to the undersigned.
8. 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.
9. 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.
10. 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.
11. 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".
12. 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:** \_\_\_\_\_

*Fax or mail your completed forms*