



How To Place Your Order

NOTE: This order form is for EXISTING Customers ONLY.

STEP 1: Obtain a prescription from your physician for the medications you would like to order. For maximum savings, we recommend you order in bulk, therefore have your doctor write you a **one year prescription in the form of a 3 month supply and 3 refills for EACH medication.**

STEP 2: Complete and sign the **CLIENT INFORMATION & MEDICAL HISTORY** form and the **ORDER INFORMATION & BILLING AUTHORIZATION** form. Fax all completed forms and **ORIGINAL PRESCRIPTIONS** to our toll-free fax at **1-866-420-8181**. You can also mail this information to us at **Canada Health Solutions, 829-6081 No 3 Road, Richmond, British Columbia, Canada, V6Y2B2**

STEP 3: Upon receipt of your order, a Customer Care Representative will contact you by phone to verify your information and confirm your order. Please allow 2-3 weeks from the day we confirm your order for processing and delivery of your prescriptions. All orders are shipped using Canada Post's Xpresspost – USA shipping service, and are fully insured against loss or damage.

**** For assistance in completing these forms, call us toll-free at 1-800-571-8399 ****

We do not ship to Canadian addresses due to local pharmacy regulations. However, if you have a friend or relative in USA, we can ship it there instead.

Client Information & Medical History

* Indicates Mandatory Fields

Affiliate ID/CPN Code: _____
(if applicable)

*First Name:		*Last Name:	
*Home Telephone: ()		*Secondary Phone: ()	
*Home Address: Street & Apt. # <small>(only if your address has changed since your last order)</small>			
*City:	*State:	*ZIP:	



Client Information & Medical History

PLEASE ADD ADDITIONAL PAGES IF NEEDED
 * Indicates Mandatory Fields

*Is this your FIRST TIME completing this form? ___ YES ___ NO	
* <u>If NO to the above</u> , when was the last time you completed this form? ___/___ <small>(mm) (yy)</small>	
*Has there been any changes to your health, medications or exercise routine since the last time you provided this information? ___ YES ___ NO	
*If YES to the above, please describe in detail ALL changes:	
*Please list ALL medical conditions you are currently receiving treatment for:	
1.	4.
2.	5.
3.	6.
*Please list ALL prescription medications currently being taken:	
1.	5.
2.	6.
3.	7.
4.	8.
*Please list ALL non-prescription medications currently being taken:	
1.	5.
2.	6.
3.	7.
4.	8.
*Please list ALL known drug allergies:	
1.	3.
2.	4.
*Name of Your Physician:	
*Physician Telephone: ()	*Physician Fax: ()

*Client Signature:	*Date: (mm/dd/yy)
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Order Information & Billing Authorization

PLEASE ADD ADDITIONAL PAGES IF NEEDED
 * Indicates Mandatory Fields

*Medications Being Ordered (must be accompanied by a valid prescription)			
Drug Name	Strength	Quantity	Refills
1.			
2.			
3.			
4.			
5.			

***Would you like a pharmacist to contact you by telephone to discuss these medications with you? ___ Yes ___ No**

***How would you like to pay for your medications? (Check one only)**

___ Visa ___ MasterCard ___ American Express ___ Money Order ___ Bank Draft

**** Please make all money orders and bank drafts payable to: Canada Health Solutions ****

*Name on Credit Card:	*Credit Card Number:
*Credit Card Verification Number: <small>(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.)</small>	*Card Expiry Date: ____/____ (mm/yy)

***Cardholder Address: Street & Apt. # (If different from above)**

*City:	*State:	*ZIP:
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***Shipping Address: Street & Apt. # (If different from above)**

*City:	*State:	*ZIP:
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***Billing Consent & Authorization**

I, _____, authorize **RX Trust Pharmacy Inc.**, provider of the RxTrustPharmacy.com service, to apply all applicable charges to my credit card. These charges include the total cost of the drugs ordered, including refills on prescriptions submitted within 90 days, and the \$15.95 shipping and handling fee, which is applied to each package RX Trust Pharmacy ships me. I understand that a 90-day supply of each medication will be shipped, unless otherwise specified. I also understand that generic substitutions will be made when available, unless otherwise specified, and that all prices and dollar amounts are in United States dollars.

*Cardholder Signature	*Date (mm/dd/yy)
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