

CANAMERICA ORDER FORM



Please fax back to CanAmerica, toll-free 1-866-982-9542

(Please Print)

YOUR ORDER

DRUG NAME	Strength	Quantity	Price (USD)
*Attach an additional sheet if you require more space		Shipping	\$10.99
		TOTAL	

YOUR PRESCRIPTION(S):

Enclosed My Doctor is faxing them to you Please contact me

PERSONAL INFORMATION:

First Name Middle Initial Last Name Gender: Male Female

Date of Birth: _____ (MM/DD/YYYY) Weight: _____ lbs

PHYSICIAN INFORMATION:

Primary Physician Name: _____

Street: _____ Phone: () _____

City: _____ Fax: () _____

DRUG PACKAGING: Please supply me with child resistant containers/packaging
 No, do not supply me with child resistant containers/packaging

PAYMENT INFORMATION:

Payment Type: VISA MASTERCARD CHEQUE OR MONEY ORDER

CARD NUMBER:

Card Holder's Name: _____

Card Holder's Signature: _____

Card Holder's Address: same as above

Telephone: () _____

Address: _____

City: _____ State: _____

Country: _____ Zip: _____

MEDICAL INFORMATION:

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Bronchitis & Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Gout |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thrombo-embolism | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> History of Stroke | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> History of Intestinal Bleeding | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis - Rheumatoid, Osteoarthritis, Lupus | <input type="checkbox"/> Angina | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory Bowel Syndrome | <input type="checkbox"/> Community -Acquired Pneumonia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer (describe below) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prostate Enlargement | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoker? | <input type="checkbox"/> Asthma | | |
| | | <input type="checkbox"/> Thyroid disorders | | |

ON A SEPARATE PAGE, PLEASE LIST:

1. SPECIFIC DRUGS TO WHICH YOU HAVE HAD A REACTION
2. ALL OTHER ALLERGIES
3. ANY PRESCRIPTION DRUG OR HEBAL MEDICATIONS YOU ARE CURRENTLY TAKING