www.CanadaWayDrugs.com

Return by Mail or Fax to:
CanadaWayDrugs.com
Suite #548   102-17750 56th Ave (#10 Hwy)
Surrey, BC V3S 1K4

Toll-Free Phone: 1 877 507 3061
Toll Free Fax Number: 1 866 308 2272
E-mail: customerservice@canadawaydrugs.com

***Hours of operation:** Monday to Friday 9am to 7pm Pacific Standard Time, Saturday 9amto 5pm
Closed: Sunday and Holidays

Thank you for your interest in our prescription service. In order to fill your prescription we will require certain information from you. To place a new order, refill prescriptions and/or inquire about product availability and prices please call our toll-free number listed above.

Patient Info and Approval
Your prescription must be authorized by a Canadian licensed physician. In order to do this you will be required to complete a medical and medication information questionnaire.

Ordering Your Prescription
Fill out the **required FORMS** section and mail your order. Please mail in your original prescriptions. Any information you provide will remain confidential and a chart will be created for you and kept by the Canadian licensed physician.

Quantities and Refills
The United States Food and Drug Administration (FDA) currently limit the quantity of medication mailed to a resident of the United States to a 3-month supply for personal use. Every 3 months you may receive a refill of your medications provided that the prescription that you submitted to us allows these refills. Once these refills have been exhausted, you will need to submit a new prescription to us.

Charges
1) Drug cost in U.S. dollars as quoted by our staff or viewed on our website. (Prices subject to change)
2) Shipping / Handling / Postage fee of $13.00 U.S. per shipment.
3) We accept:

Cashiers Cheque	Made out to **Ultra Care Pharmacy Ltd.**
International Money Order	Made out to **Ultra Care Pharmacy Ltd.**
Visa	
MasterCard	
American Express	There may be a 5% up-charge for conversion fees
Discovery	There may be a 5% up-charge for conversion fees

Please Include:
A. Your PRESCRIPTIONS
B. Your SIGNED FORMS:

1) Patent Information
2) Medical Information
3) Medication Information
4) Patient Identification
5) Customer Agreement (A & B)

C. Your PATIENT IDENTIFICATION

Patient Forms
Filling out these forms should only take a few moments of your time but it is very important to do so. It will enable us to safely and efficiently fill your prescription. This in turn will grant you access to high quality prescription medications but at a much lower Canadian prices. If you have found our prescription service helpful tell a friend.

Please Be Advised
Due to governing body regulations, we DO NOT ship vitamins, food supplements, narcotics and controlled substances like: amphetamines, benzodiazepines (e.g. Valium), compounded products or refrigerated items. We feel that we can best serve your needs if we concentrate on providing you with maintenance medications such as: high blood pressure, diabetes, arthritis, and cholesterol medications etc.

Availability
Not all U.S. prescription drugs are available in Canada. Any generic drug dispensed has been approved for use & substitution by Canadian officials.

Shipping and Processing
Once we receive your order, **patient forms, valid prescriptions, and patient I.D.**, your order will be shipped within 2-4 days. Shipping usually takes about a week. All orders are shipped via Canada Post and the U.S. Postal Service. If you do not receive your order within 3 weeks, please contact us @ 1 877 507 3061 after an order has been shipped there is no cancellation.

Return Policy
As per the College of Pharmacists of British Columbia Bylaw 5 (33. (1)), medications are not returnable or exchangeable.

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Please keep this page for your records. You do not need to fax or mail this page.

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PLEASE PRINT

PATIENT INFORMATION

First name		**Middle Name:**	
Last name		**Gender:**	**Male** **Female**
Date of Birth:	M D Y	**Weight (lbs):**	
Home Phone		**Work Phone**	
Fax Number		**Cell Number**	
		e-mail	

PRIMARY ADDRESS

Street or P.O. Box		**City or Town**	
Zip Code		**State & Country**	

SHIP TO ADDRESS (If different than primary address)

Street or P.O. Box		**City or Town**	
Zip Code		**State & Country**	

PRIMARY PHYSICIAN

Name		**Phone**	

SECONDARY CONTACT PERSON

Name		**Phone**	
Relationship			

Important!

It is mandatory to have had a physical examination in the last 12 months.
Have you had a physical examination in the last 12 months? Y ☐ N ☐
If not, we will require that you visit your physician before we will be able to fill your prescription.

Patient's Name (please print) | Date | Patient's Signature

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MEDICAL INFORMATION

Please check all the medical conditions that you "currently" have:

Alzheimer's disease	Dermatological problems (please describe below)	Hysterectomy
Anxiety	Diabetes (please describe below)	Kidney or Renal disease
Arthritis: Rheumatoid, Osteoarthritis, Lupus	Edema (water retention)	Liver Disease
Asthma	Epilepsy	Osteoporosis
Blood disorder	Glaucoma	Parkinson's disease
Cancer (please describe below)	Heart disease (please describe below)	Schizophrenia
COPD – Bronchitis & Emphysema	High cholesterol	Stomach/intestines problems (please describe below)
Depression	High Blood Pressure	Thyroid disorders
Dementia	HIV / AIDS	Tobacco (Do you smoke?)

Please use the space below to add additional comments regarding the medical conditions you have selected above and or other medical conditions not listed.

____

____

____

DRUG ALLERGIES NO ☐ YES ☐

If yes, please check the drug group and circle the corresponding medication or list medications in the space provided.

A.C.E. Inhibitors: Vasotec, Altace, Zestril, Accupril, Capoten	Histamine H2 Inhibitors: Zantac, Tagamet, Pepcid	Proton Pump Inhibitors: Aciphex, Nexium, Protonix, Prilosec, Prevacid
Beta Adrenergic Blocking Agents: Inderal, Tenormin, Sectral, Betapace	HMG-COA Reductase Inhibitors: Lescol, Zocor, Pravachol, Lipitor, Mevacor	Quinolones: Cipro, Noroxin, Levaquin
Calcium Channel Blocking Agents: Norvasc, Diltiazem, Verapamil, Plendil, Nifedipine	Hydantoins: Phenytoin, Dilantin	Selective Sorotonin Reuptake Inhibitors: Prozac, Zoloft, Luvox, Celexa, Paxil
Carbamazepine (Tegretol)	Macrolides: Biaxin, Erythromycin, Zithromax	Sulfonamides: Bactrim, Septra, Cotrim, Celebrex, Flomax, Glyburide, HCTZ
Cephalosporins: Keflex, Ceclor, Cefzil, Ceftin	NSAID's: Naprosyn, Aspirin, Relafen, Voltaren, Indocid, Motrin	Tetracyclines: Tetracycline, Minocycline, Doxycycline
Cox-2 Inhibitor: Vioxx, Celebrex, Bextra, Mobic	Penicillins: Amoxil, LedercillinVK, Ampicillin, Augmentum	Other, Please use space below

Please use the space below to add additional comments regarding the allergies you have selected above and/ or other allergies not listed.

____

____

____

Patient's Name (please print) ____________ Date ____________ Patient's Signature ____________

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MEDICATION INFORMATION

MEDICATIONS CURRENTLY TAKING

	Medication	Strength	Directions		Medication	Strength	Directions
1				5			
2				6			
3				7			
4				8			

MEDICATIONS BEING ORDERED

Qty	Medication	Strength	Do you want generic drugs?	Price	Had this drug before?
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐
			Y ☐ N ☐		Y ☐ N ☐

SHIPPING: 13.00

TOTAL U.S.D: $ ______

MEDICATION PACKAGING REQUESTED

PLEASE SELECT ONE:

1. Original packaging in manufacturer units depending on the drug. No safety caps and may contain “stay-dry” desiccant beads. ☐
2. Re-Packaged into pharmacy vials with Child-Resistant (Safety) Caps. ☐
3. Re-packaged into pharmacy vials with Easy-Open Caps. ☐

Patient’s Name (please print)	Date	Patient’s Signature

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PLEASE PRINT

PATIENT IDENTIFICATION

We need to obtain a copy of one primary or two secondary identifications in order to fill your prescriptions in accordance with the College of Pharmacists of British Columbia.

PRIMARY IDENTIFICATION

Provide ONE of the following:

1. Valid State Driver's License
2. Valid Passport
3. Valid State or Federal Identification Card

OR

SECONDARY IDENTIFICATION

Provide TWO of the following:

1. Birth certificate
2. Marriage Certificate
3. Citizenship Papers, e.g. Green Card, DNS card
4. Military I.D. or Discharge Papers from U.S. Forces
5. Certificate of License from a regulated profession, e.g. Doctors, medical, naturopathic, veterinary, podiatric, dental, lawyer, nurse, pharmacist, registered dietician, engineers, CPA, teacher
6. Gun License or Permit
7. Bank Credit Card, e.g. Visa, MasterCard, American Express (please black out the last set of numbers)
8. Social Security Card
9. Medicare Card

PAYMENT INFORMATION

Cashiers Cheque or International Money order made out to:
Ultra Care Pharmacy Ltd.

Credit Card Type

	Credit Card Type		
________	Visa	Credit Card Number:	________________
________	MasterCard		
________	**American Express	Expiration:	Month ______ Year ______
________	**Discovery		

****There may be a 5% up-charge for conversion fees added to your order.**

Cardholder's Name		**Cardholder's Signature**	

Make sure you have contacted your credit card company to let them know you will be making a purchase from Canada.

______________________ ______________ ______________________
Patient's Name (please print) Date Patient's Signature

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CUSTOMER AGREEMENT (part A)

No prescription will be filled without a signed and dated copy of this form

I, as the undersigned, being over the age of 21, hereby:

Disclosure and Representations

Represent and confirm to www.CanadaWayDrugs.com, its affiliates, related companies, subsidiaries and parent company (hereinafter collectively referred to as CanWD) that:

1. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment.
2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician.
3. I will use any medication obtained for me by CanWD strictly according to the instructions provided by the physician who prescribed the medication.
4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.
5. I can make my own medical decisions according to the law of the place where I reside.
6. The prescription(s) I am requesting CanWD to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to CanWD.
7. I am not seeking or relying on any medical information from CanWD and I have consulted a qualified physician licensed where I obtained the prescription within the last year.
8. I will immediately contact he physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by CanWD.
9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contradiction to me taking the medications being prescribed.
10. I acknowledge that CanWD's employees and agents have relied on the information and documentation that I am providing (including the Medical and Medication information) and I represent and confirm that I have fully disclosed all pertinent information and documentation to CanWD. I agree to notify CanWD of any changes to my physical or medical condition by providing an updated patient profile.

Authorization and Consent

11. I hereby authorize and appoint CanWD, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription in **Canada** that is to equivalent of the prescription that I sent to CanWD, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to CanWD employees, agents and service providers including the **Canadian** Physician being retained on my behalf, as required, for the limited purpose of obtaining the **Canadian** prescription. The authorizations and consents that I am profiling to CanWD commence on the date I have signed this agreement and shall continue until I revoke them. I understand that I can revoke the consent and authorizations I have granted to CanWD at any time.
12. I hereby specifically acknowledge that I am aware the CanWD will be transmitting my personal health information by electronic means (for example: fax and secure internet) to its employees, agents, affiliates and service providers including the **Canadian** physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order, I also understand that CanWD, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to CanWD's transmission of my personal health information by electronic means.
13. If I was directed to CanWD's services through an affiliate of intermediary (for example: Pharmacy Benefit Manager, Health Management Organization, or other health care service provider), I hereby authorize CanWD to release the following data to such an intermediary:
    a. A numerical identifier indicating that I was a patient referred from that source;
    b. Financial information that will permit the processing of any claims on my behalf;

    It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of CanWD relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

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14. I hereby authorize and appoint CanWD, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do personally if I were present taking those steps and signing those documents myself.
15. I authorize and appoint CanWD as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.
16. I acknowledge and agree that I initiated a consultation with CanWD and that CanWD is not located in the United Stats. I also acknowledge that the pharmacists working for CanWD and the physicians contracted by CanWD on my behalf are licensed to practice medicine or pharmacy.
17. I agree that CanWD may release my personal health information to the person(s) listed as my "secondary contact' in the patient information form.
18. I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and CanWD shall be deemed to be made in the Province of British Columbia, Canada and accordingly shall be governed by the laws of the province of British Columbia and the laws of Canada applicable to such contracts and agreements.
19. I agree that any dispute that arises between me and CanWD, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of the Province of British Columbia and the laws of Canada applicable to contract formed in the province of British Columbia, and I agree that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute.

Purchase and Sale Terms

20. CanWD will charge my credit card for the following amounts:
    a. The medication price plus shipping and handling as posted on the CanWD website on the day CanWD receives my order; and
    b. In the event my payment is not authorized, CanWD has the right to cancel my order and attempt to provide me with notice of such cancellation.
21. The pharmaceutical(s) will be packaged as per my request in the **Medication Packaging** section of this form.
22. CanWD shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless the physician has indicated that there be "no substitution" or dispensed as written. That once purchased and shipped, no pharmaceutical product may be returned or exchanged.
23. CanWD reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitles to a refund of monies paid for such order.
24. CanWD does not provide its agency or attorney services as a substitute for healthcare or the advice of the customer's primary care physician.
25. CanWD will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.

I have read and understood the terms and conditions set out in the Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns to be bound by these terms and conditions.

Signed this ______ day of __________________, 20____

_______________________________________ ___________________________
(Signature) (Print Name)

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CUSTOMER AGREEMENT (part B)

Consent and declaration from U.S. patient

I, ____, provide my consent to allow a physician licensed in Canada to obtain my medical history, drug history, contact information and other necessary documentation from my U.S. physician. In this context, I further consent to both the Canadian physician and my U.S. physician being able to contact one another to discuss my medical condition, as it pertains to the prescribing of the medication(s) in question. I understand that the reason for this consent is to provide the Canadian physician with a full opportunity to conduct and independent analysis of whether the medication(s) prescribed by my U.S. physician is appropriate, and discuss any potential medical complications that may arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence. I further allow the Canadian physician to share the information with any Canadian pharmacists in the process of filling my prescriptions.

I further agree to regularly visit my U.S. physician (s) and to promptly advise the Canadian physician and CanWD of any changes in my medical condition, allergies, or prescription.

______________________________	____________________	______________________________
Patient's Name (please print)	Date	Patient's Signature