

**Form 1**

**Generic Pharmacy**

**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: \_\_\_\_\_

**MY PRIMARY PHYSICIAN**

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

**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"***

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**Form 2**

**Generic Pharmacy**

<b>MY PERSONAL MEDICAL HISTORY</b>
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\* 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:** \_\_\_\_\_

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Form 3

Generic Pharmacy

**PRESCRIPTION REQUEST FORM**

Medication	Strength	Dose	Quantity	Price
1.				
2.				
3.				
4.				
5.				
6.				
<b>Shipping and Handling: There will be a \$15.00 shipping fee per household ordered at the same time</b>				
<b>TOTAL (all amounts are in US dollars)</b>				

**MY BILLING INFORMATION**

Please input the EXACT credit card billing information, or your order will be delayed.

Type of card: Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ American Express \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

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

Address to send receipt to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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 is missed
- The importance of taking the drug as directed
- Food, drink, other drugs or activities to avoid
- Common side effects
- How and when the drug should be taken
- Special storage requirements
- Refill information

***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: \_\_\_\_\_

Would you like our pharmacist to contact you to discuss any of these issues?

Please circle:           **YES**           **NO**

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**Form 4**

**Generic Pharmacy**

**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

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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:** \_\_\_\_\_

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