

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: RIMEDS, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-656-(MEDS) 6337

PATIENT INFORMATION: Phone (Home) _____ Phone (Work) _____ First Name (please print) _____ Initial _____ Last Name _____ Street Address _____ City/State _____ Zip Code _____	NOTE: If acceptable to the prescribing physician, each prescription should request a 3-month supply of medication with 3 refills . New-to-you medications must be tried for a period of 30-days before ordering through the RIMEDS Program. You may be contacted by one of our representatives, physicians or the network pharmacy filling the prescription to discuss or confirm your order.
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List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements. <small>(This is NOT a prescription.)</small>	Strength	Daily Use	Generic
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>
			YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) Male Female Birthdate _____ DD/MM/YY _____

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalization: (stays in hospital during the past 5 years) _____

(iii) Present Illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug Allergies: NO YES If yes, please specify: _____

Physician's Name: _____ Physician's Signature: _____ OPTIONAL Date DD/MM/YY _____

PAYMENT INFORMATION

Cardholder Name _____ Credit Card Number _____ Expiry (m/y) _____

VISA MASTERCARD CERTIFIED CHECK * OR MONEY ORDER *
(* Must be mailed directly to CanaRx Services Inc.)

Signature of Cardholder _____ Date DD/MM/YY _____

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medications for a period of more than 30 days. I certify that I have read and understand the terms of agreement on the reverse and that the information provided by me is accurate and true.

Patient Signature _____ Date DD/MM/YY _____

THIS FORM MUST BE ACCOMPANIED WITH THE WRITTEN PRESCRIPTIONS OF YOUR U.S. PHYSICIAN.