

- ✓ Please fax these forms along with your original doctor’s prescription for new orders toll free to 1-888-779-3784 Or Mail to: Mailscripts, Inc. 605 W. Main Street, Saint Charles, IL 60174
- ✓ Please list any refill orders you also want from us.
- ✓ Visit www.msi.0catch.com for order forms and contact information
- ✓ Call us toll free at **1-888-479-3789** for help 24 hours per day

GENERAL CLIENT INFORMATION

Discount Code AG5D-17

Mr. Ms. Mrs. Miss Dr. Other _____

First / Middle / Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone (incl. area code): _____ Work Phone: _____

Fax (incl. area code): _____ E-Mail: _____

Your Height and Weight: _____ Date of Birth (MM/DD/YYYY): _____

Gender: **Male** **Female**

YOUR PHYSICIAN INFORMATION

First / Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

YOUR PERSONAL MEDICAL HISTORY

Have you filled out a questionnaire with us before? **YES NO**

If yes, when and have there been any changes since then? (MM/DD/YYYY): _____

Changes:

NEW ORDER AND REFILLS REQUIRED (continue on separate sheet if required)

Please list all medications you are requesting in this order:

Name of Drug	Date First Prescribed	Strength	Quantity (we ship in manufacturer quantities only and suggest a 90 day supply)	US\$ Cost (see our website, or we will call you to confirm pricing)
			ORDER TOTAL:	\$
			PLUS SHIPPING:	\$15.00
			GRAND TOTAL:	\$

PAYMENT METHOD

VISA, MasterCard, American Express, International Money Orders or Bank Drafts are accepted for your convenience. International Money Orders or Bank Drafts will delay processing your order and should be made out to Canada Direct Pharmacy Ltd. and faxed with this form and then mailed to our administration center at: **Mailscripts, Inc. 605 W. Main Street, Saint Charles, IL 60174.**

By signing below, I authorize my credit card to be charged for the medications prescribed plus US\$15 for shipping costs:

Card Holder Name: _____ Signature _____

Card Holder Address (as it appears on your billing statement): _____

Card Holder City / State / Zip: _____

Card Type: MasterCard Visa American Express

Credit Card Number: _____ Expiry (MM/YYYY): _____

Date Signed (MM/DD/YYYY): _____