

✓ Please fax this form for refills of prescriptions previously ordered through Mailscripts toll free to 1-888-779-3784
 Or Mail to: Mailscripts, Inc. 605 W. Main Street, Saint Charles, IL 60174

- ✓ 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 PATIENT INFORMATION

Discount Code AG5D-17

Mr. Ms. Mrs. Miss Dr. Other _____

First / Middle / Last Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Date of Birth (MM/DD/YYYY): _____

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

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 Type: MasterCard Visa American Express

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

Date Signed (MM/DD/YYYY): _____