Medical Order Form

Phone: 1-855-353-2879
Fax: 1-833-353-2879
Email: info@electrx.com

Elect Rx

Step 1: Your Contact Details & Medical Profile

Please complete all fields below, making sure to print clearly. This information is required by our pharmacy staff and will remain confidential. This section is important as our pharmacy staff review your medical background to confirm that the medications dispensed will not conflict with any existing medical conditions.

First Name: _____ Last Name: _____
Height *(if under 12 years)*: _____ Weight *(if under 12 years)*: _____
Date of Birth *(MM/DD/YY)*: ___/___/___ Sex: ☐ Male ☐ Female
Are you a smoker: ☐ Yes ☐ No E-mail: _____
Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No
If so, what is your due date? *(MM/DD/YY)* ___/___/___

Do you have any known drug allergies? *(If not, please write None)*:

_____

_____

Please list your medical history and current illnesses / conditions:

_____

_____

Name of Employer/Group: _____
Relationship to Employer: ☐ Employee/Self ☐ Spouse/Partner ☐ Dependent
Refill Reminder Notification Preference: ☐ Home Phone ☐ Mobile Phone ☐ Email

Prescribing Physician Name: _____
Physician Phone Number: _____ Physician Fax Number: _____
Physician address *(if known)*: _____

Please note: your shipping address must be an address that USPS (United States Postal Service) delivers to.

Shipping Address Line 1: _____
Shipping Address Line 2: _____
Shipping Address City: _____ Shipping Address State: _____
Home Phone Number: _____ Mobile Number *(optional)*: _____

We will notify you that a refill order is processing, your refill order will be processed automatically 48-hours after this notification, please advise us within the 48-hour time period regarding any changes in medication or address details.

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Step 2: Your Order Details

Please complete the details of your order below. To complete medication details please refer to the most current ElectRx formulary. If your medication is not listed please contact our customer service center at **1-855-353-2879** to inquire regarding availability, or email us directly at **info@electrx.com**.

Please check the appropriate box below to let us know how we will receive your prescription(s). ***If you have not previously taken the medication(s) you are ordering today, please check "Yes" for "New medication?".***

Please note: if your medication is not listed on the ElectRx medication formulary it may be due to the availability of less expensive alternatives in the USA.

MEDICATION NAME	STRENGTH	HOW MANY PER DAY?	NEW MEDICATION?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

☐ I have attached my prescription(s) with this order form.

☐ I will arrange for my doctor to fax my prescription(s) to **1-833-353-2879**.

☐ Please fax my doctor to request a copy of my prescription(s):

Provider Phone #: _____

Step 3: Your Current Medication

Please complete details of all medications and supplements you are currently taking and the condition they are for. This section is important as our pharmacy staff review your medical background to confirm that the medications dispensed will not conflict with any other medications or supplements you are taking.

MEDICATION NAME	STRENGTH	HOW LONG TAKEN FOR?	ILLNESS/CONDITION

By signing this form I agree to have my medication shipped under the personal importation program offered by ElectRx.

Signature: _____

Date: ___ /___ / ___

Is this your first order with ElectRx? ☐ Yes ☐ No

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Step 4: Fax Your Completed Order Form To Us

Once you have filled out all the information on this form, please fax all pages along with a copy of your **valid U.S. prescription** to **1-833-353-2879**. Please ensure you have completed all fields, as your order may be delayed if your form is incomplete.

Please do note that if you supply a P.O. Box for your shipping address that we will require a physical address to be supplied for our records.

After we receive your fax, your eligibility will be confirmed and your order will be processed by our staff and shipped. If your plan type is a high deductible plan requiring payment, we will contact you directly by phone for your payment details.

If you have further questions, please call one of our customer service representatives on **1-855-353-2879** or email us at **info@electrx.com**.

TRUE NORTH MEDS INC is a pharmacy that specializes in providing distance care from a head office located in Winnipeg, Manitoba, Canada. For more information on term and conditions, with respect to the sales and delivery of medication, you can visit True North Meds Inc website at www.truenorthmeds.com.

In addition the following regulations, term and conditions governs all sales between TRUE NORTH MEDS INC, and the patient.

The patient is of the age of majority and legally entitled to purchase and receive the medications requested of TRUE NORTH MEDS INC ("True North") and its Partners or Agents, and:

I. The patient wishes to purchase medication from, and have their order filled by a licensed pharmacy in Canada.
II. The patient has been examined with in the last 12 months and has received a lawfully prescribed prescription from a physician licensed to practice medicine within the patient's home jurisdiction. The patient is not seeking medical advice or relying on medical information from True North or their agents.
III. The patients consents to True North and their agent physician being able to contact the patient's physician, who issued the prescription, as it pertains to prescribing and dispensing of their medications. The patient understands that the reason for this consent is to provide each agent physician and True North with the opportunity to conduct an independent analysis of whether the prescription obtained is suitable and to discuss any medical conditions that may arise.
IV. The prescription has not been altered in any way, nor has it been filled prior to submission to True North.
V. The patient will immediately contact their physician who prescribed their medication, if they suffer any unexpected side effects from medications ordered from True North.
VI. The patient understands that the medications are sold, dispensed and delivered within the jurisdiction of where the dispensing pharmacy operates. In the case of TRUE NORTH, this jurisdiction is Winnipeg, Manitoba, Canada. The patient understands that they are the one shipping the medication, not TRUE NORTH.
VII. The patient agrees to use the medication ordered through True North, according to the instructions stated by the physician who provided the prescription, at the patient's home jurisdiction. The patient will not allow anyone else to use their medications.
VIII. The patient has fully and accurately disclosed their personal and health information and authorizes TRUE NORTH to collect and use the information for the processing and delivery of the orders placed by the patient.
IX. The patient grants to TRUE NORTH power of attorney to take all steps, sign all documents, and act on the patient's behalf for the purposes of obtaining an equivalent prescription recognized and valid within the dispensing pharmacy's jurisdiction. This would be the same steps that the patient would perform if they were present in the pharmacy's jurisdiction. This shall include but not limited to collecting and using the patient's personal and personal health information as is needed to process their order. This shall continue until the patient revokes permission, which can be done at any time.
X. The patient adheres to the jurisdiction of the dispensing pharmacy's operations. All agreements reached or contracts formed will be made in the jurisdiction of the pharmacy, the laws of the jurisdiction shall govern all transactions, and the courts in the jurisdiction of the pharmacy shall be sole and exclusive authority regarding any dispute arising between the patient and the dispensing pharmacy.
XI. The patient agrees to notify the dispensing pharmacy, in writing, of any changes in their drug therapy 20 days prior to medication being shipped.
XII. The patient understands that they accept responsibility for shipping and receiving their medication. The patient accepts that there may be delays, such as customs holding the package, and that True North has no control over unexpected delays. True North takes all necessary precautions to pack your items in a safe and reliable manner. The patient agrees that they are responsible having someone to sign and accept shipments that requires a signature on delivery. True North is not responsible for shipments that arrived, and no one was available to sign for delivery. medication. The patient accepts that there may be delays, such as customs holding the package, and that True North has no control over unexpected delays. True North takes all necessary precautions to pack your items in a safe and reliable manner. The patient agrees that they are responsible having someone to sign and accept shipments that requires a signature on delivery. True North is not responsible for shipments that arrived, and no one was available to sign for delivery.

I HAVE READ AND UNDERSTOOD THESE TERMS AND CONDITIONS SET OUT ABOVE AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES.

OR. "I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

Signature: _____

Date: ___ /___ / ___