

To refill your prescription(s) by fax, complete this Medication Refill Form and fax it to our 24-hour Toll-Free Fax Service: 1.866.795.5627

The Canadian Pharmacy will bill your order using the information we have in your file. If there have been any changes, please enter your updated information below or call us toll-free and let us know.



103 - 1780 Wellington Avenue
 Winnipeg, Manitoba, CANADA R3H 1B3
 Phone: (204) 697-5910
 Fax: (204) 697-5919

Toll-Free Phone: 1.866.335.8064
Toll-Free Fax: 1.866.795.5627

www.thecanadianpharmacy.com
info@thecanadianpharmacy.com

Date: _____
 (DD/MM/YYYY)

SHIPPING INFORMATION:

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ (day) _____ (evening)

Email Address: _____

(Please check <input checked="" type="checkbox"/>)				Medication Name	Strength	Quantity	Price (USD)
Brand Only	Generic Preferred	International Permitted	Is this a New Medication?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
Prescription Drug Total							\$
Add \$15.00 Shipping (Insured, trackable ExpressPost USA)							\$15.00
Total (U.S. Funds)							\$

Please Note: Due to supply restrictions imposed on TCP and other Canadian IPS pharmacies by certain pharmaceutical manufacturers, pricing may vary. Supply is subject to availability.

BILLING INFORMATION: **VISA** **MasterCard**
Desired Payment Method: **Personal Check** **Money Order**

Credit Card #: _____ **Expiry Date** _____

Name on Credit Card: _____

Cardholder's Signature: X _____

(I authorize The Canadian Pharmacy to bill my credit card for this order)

When is the most convenient time for a pharmacist to contact you? During the Day? Evenings?

Child resistant closures, where appropriate, are mandatory in Manitoba unless patients decline their use. If you DECLINE child resistant safety closures please check here.

Safeguarding the confidentiality of your personal information is a primary concern at TCP. TCP will not release any personal, medical or financial information to anyone other than the health professionals responsible for filling your prescriptions, without your written consent.

Medication Refill Form