

Prescription Submission

Use this form to submit your prescription(s).
Send it back to us to complete your order.

| | | |
|--------------|-------------|----------------------|
| _____ | Patient ID: | <input type="text"/> |
| Full Name | | <input type="text"/> |
| _____ | Order ID: | <input type="text"/> |
| Phone Number | | <input type="text"/> |

Your Physician

| | | | |
|--------------------------|----------------|-----------------------------|-----------------|
| _____ | | _____ | |
| Primary Physician's Name | | Clinic Name, Street Address | |
| _____ | _____ | _____ | _____ |
| City | State/Province | Country | Zip/Postal Code |
| _____ | _____ | _____ | _____ |
| Phone Number | Ext. | Fax Number | Email |

Option 1: Email or Fax a copy of your prescription(s) and then mail originals.

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| <p>Scan or use your camera (smartphone) to take a <u>clear</u> picture of your original prescriptions, then email them in full quality to:</p> <p>To: prescriptions@CanadaOnOHHDOP <input type="checkbox"/></p> <p>Subject: Prescription(s) for (type your name)</p> <p>OR Send by Fax: 1-800-988-5440</p> | <p>Sending the scan will allow your order to continue processing. Please mail your original prescription to:</p> <p>Canada Online Health 306-1500 14 St. SW Calgary, Alberta, Canada T3C 1C9</p> |
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Option 2: Contact Your Doctor*

| Please list the medications you would like us to call your doctor about. | | | |
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* Contacting your doctor is only available to residents of the United States and Canada