TB/JS
Joe Santiago
407-265-3244

Glenway Mail Order Pharmacy

Mail to: Health Insurance Options 307 Oakwood Ct Fern Park, FL 32730
Fax to: 407-574-3095

Your Full Name ___________________________ Date of Birth ______________________________

Address__________________________________ Height ___________________________________

City ____________________________________ Weight___________________________________

State/Province ____________________________ Sex_______________________________________

Zip/Postal Code __________________________ Country __________________________________

Phone Number (____)_____________________

Spouse or other person's name if you want packages shipped together__________________________________

Have they previously filled out a Questionnaire?___________

Primary Physician's Name____

Address____

Phone (____)______________________ Fax (____)________________________

Please note: it is mandatory to have had a physician's examination in the last 12 months. Have you had one?________________

Please list all medications you are currently using, including the dosage and frequency.

Medication Name	Strength/dosage	Direction for use

Please list all known allergies____

Patient Profile

Patient Name____

Patient medical history
Do you have a history or early finding suggestive of the following? (Please check all that apply)

- ❑ Blood disorders
- ❑ Cancer
- ❑ Immune disorders
- ❑ Poor wound healing
- ❑ Edema or excessive fluid retention
- ❑ Neurological disorders
- ❑ Thyroid, diabetes or other endocrine disorder, including insulin resistance
- ❑ Any known nutrition deficiency including minerals and electrolytes
- ❑ Hyperlipidemia (high cholesterol)
- ❑ Upper respiratory disorders, ears, nose, throat
- ❑ Smoker
- ❑ Lung disorder (ie., asthma, emphysema)
- ❑ High blood pressure
- ❑ Heart disease including atherosclerosis, angina, chest pains, palpitation, heart failure or history of heart attack
- ❑ Renal, bladder or kidney disease
- ❑ Liver disease
- ❑ Drug allergies
- ❑ Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome
- ❑ Emotional disorders, stress
- ❑ Surgery
- ❑ Glaucoma
- ❑ Chemical dependency
- ❑ Other illness not yet noted
- ❑ Medications used in the past 12 months
- ❑ Rheumatoid arthritis, lupus, or connective tissue diseases
- ❑ Regular exercise

What type, frequency and duration of exercise..____
____

If you checked any of the above questions, please elaborate below (i.e. duration of illness, any treatment or surgery received, amount smoked and for how long?)____
____

Order Form

Medication being ordered	Dosage or strength	Quantity	Generic substitution	Price in US dollars

Shipping Charge: $10.00 US
Total: $_______________US

Credit Card Information

Name on card___________________________
Credit card number______________________
Credit card expire_______________________

Address_____________________________
City_________________________________
State _______________________________
Zip Code____________________________

___Visa ___MasterCard

***Money orders** are the preferred method of payment. Personal cheques are accepted but must clear before processing will begin. This may add up to 7 days to the shipment times. (No third party cheques accepted.)

Note in order to order from Glenway Pharmacy you must have been on the medication for a minimum of 30 days.

Informed consent for **Patient Counseling:**
We provide patient counseling from a licensed pharmacist on all prescriptions.
This includes:
1.Medication identification (name, dose and use)
2.Directions for use and what to do if you miss a dose
3.Drug or food interactions and common side effects
4.Special storage requirements and refill information
Would you like a pharmacist to call you to discuss your medication ___yes ___no

Signature:____Date:________________

User Agreement Form

No prescriptions will be filled without a signed and dated copy of this form

The undersigned, (hereinafter the Patient") confirms that:

1. The Patient is of the age of majority in the jurisdiction, in which the Patient resides and is fully competent to make their own health care decisions.

2. The Patient confirms that the pharmaceutical(s) ordered by the Patient ("the Ordered Product") were prescribed by a duly qualified medical practitioner in the place of residence of the Patient. The Patient has not violated any laws in obtaining the prescription and that the Ordered Product will not be used by no other person and in no manner except as prescribed by the original prescribing physician ("The Patient's Physician").

3. By reviewing the Patient's medical information, the Canadian Physician is not providing any service or advice to the Patient. The Patient confirms that they did not request a medical opinion of the Canadian licensed co-signing Physician regarding the Ordered Product. The Patient agrees to direct all questions to The Patient's Physician. The Patient will consult The Patient's Physician before taking any new drug, natural product, or changing their daily health regiment.

4. Glenway Pharmacy requires the patient to submit a new medical questionnaire every time there is a change to their medical status. The Patient understands that it is their responsibility to have The Patient's Physician conduct regular physical examinations (minimum every 12 months), including any and all suggested testing by The Patient's Physician to ensure that they have no medical problems which would constitute a contradiction to them taking medications prescribed for them. The Patient agrees that should they suffer any adverse affects while taking any prescription medication that they will immediately contact The Patient's Physician and that in the event they come under the care of another physician, the Patient will inform this physician of any and all medications that have been prescribed.

5. The Patient agrees to release and discharge Glenway Pharmacy and all of its Employees, including the Doctors and Pharmacists, from all liability, claims, or causes of action with respect to any side effects, the appropriateness, suitability, strength or dosages of the pharmaceutical(s) prescribed for the undersigned.

6. The Patient understands and acknowledges that the Ordered Product(s) will not be packaged in child protective packaging. The Patient assumes all responsibility for safe and secure storage, restricting non-patient access to the medications.

7. The Patient releases and discharges Glenway Pharmacy and its Employees from any and all causes of action with respect to the late delivery, non-delivery or missed delivery of the Ordered Product(s) sent to the Patient. The Patient must take responsibility to secure their own medication stock from a local pharmacy in the interim if such an event was to evolve, ensuring that at no point they are without medication.

8. The Patient grants Limited Power of Attorney to Glenway Pharmacy, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Ordered Product to the Patient, in the same manner as the Patient could, if the Patient had personally attended the pharmacy in Winnipeg, Manitoba, Canada.

9. The Patient agrees that any dispute that arises between Him or Her and Glenway Pharmacy shall be heard by the courts of Manitoba, Canada. The courts of Manitoba, Canada shall have the sole and exclusive jurisdiction, and that the laws in force in Manitoba, Canada, shall apply to any and all disputes that may arise.

10. The Patient must honestly report all requested information and immediately update any changes to his or her record.

11. The Patient understands that the Ordered Product may not be exchanged or returned for a refund once purchased and shipped.

BY SIGNING THIS DOCUMENT THE PATIENT CONFIRMS THAT HE OR SHE HAS READ AND UNDERSTOOD EACH OF THE ABOVE TERMS AND HAS AGREED TO EACH ONE.

Name: ___________________________ Date: ___________ Signature: ___________________________________