



ORDER FORM

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<p>PLEASE PRINT IN BLOCK CAPITALS</p> <p>Mr/Mrs/Ms/Dr Last Name _____</p> <p>First Name _____</p> <p>Home Address _____</p> <p>Suburb _____ Postcode _____</p> <p>IF DELIVERY ADDRESS IS DIFFERENT FROM THE ABOVE ADDRESS THEN PLEASE FILL IN BELOW</p> <p>Business Name _____</p> <p>Delivery Address _____</p> <p>Suburb _____ Postcode _____</p> <p>Contact Phone number (We must have a phone number to process your order) Mobile () _____</p> <p>Work () _____ Fax () _____</p> <p>Home _____ Email _____</p>	<p>PAYMENT METHODS</p> <p><input type="checkbox"/> Cheque/Money order for \$ _____</p> <p><input type="checkbox"/> Credit Card <input type="checkbox"/> BANKCARD <input type="checkbox"/> VISA</p> <p><input type="checkbox"/> MASTERCARD <input type="checkbox"/> DINERS# <input type="checkbox"/> AMEX#</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;">Authorisation Code*: _____</p> <p>Expiry Date ___/___/___ Contact phone number () _____</p> <p>Signature _____</p> <p>Only signed orders can be accepted. Order will only be sent once funds have been cleared.</p> <p># 3.0% surcharge to use Amex or Diners * Visa/Master: Last 3 digits at the back of card. Amex: 4 digit on front</p>
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PATIENT PROFILE

PLEASE COMPLETE DETAILS BELOW FOR EACH PERSON IF ORDERING ANY MEDICINES OR PRESCRIPTIONS AND THIS IS THE FIRST TIME YOU HAVE ORDERED FROM US. YOU CAN ATTACH OTHER PATIENT PROFILES TO THIS ORDER FORM IF REQUIRED. WRITE THE PATIENT NAME NEXT TO EACH MEDICINE ORDERED BELOW.

<p>Patient's full Name _____</p> <p>Address (if different to above) _____</p> <p>Suburb _____ Postcode _____</p> <p>Date of birth ___/___/___ Sex M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Health Care Card/Pension Card/Repat/Safety Net Entitlement Card. You must include a photocopy of your card the first time you use us.</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p>Your Doctor's Name (optional) _____</p> <p>Address _____</p> <p>Suburb _____ Postcode _____</p> <p>Doctor's Phone _____ Fax No _____</p> <p>Medicare card number. Compulsory if ordering any PBS prescription. Fill all 11 boxes and expiry date. The last digit is the number next to the first name.</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: right;">EXP DATE ___/___/___</p>	<p style="text-align: center;">Please cross [X] the appropriate box(es) below :</p> <p>Do you have any drug allergies?</p> <p> <input type="checkbox"/> No drug allergies <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Erythromycin <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Tetracycline <input type="checkbox"/> Other – please specify _____ </p> <p>Do you have any of the following medical conditions?</p> <p> <input type="checkbox"/> No chronic conditions <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Condition <input type="checkbox"/> High blood pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Thyroid <input type="checkbox"/> Other condition – please specify _____ </p> <p>Are you on any other medication including non prescription medication? Please specify _____</p>
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CODE (if known)	NAME OF PRODUCT Please give full details of each product ordered	PATIENT NAME For ALL medicines ordered	QTY	PRICE\$

<p>Would you like a less expensive equivalent brand if available and with your doctor permits? YES <input type="checkbox"/> NO <input type="checkbox"/> Do you require a receipt for your private health fund? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Would you like us to keep your repeat prescriptions for ease of future re-order? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>SUBTOTAL</p> <hr/> <p>PLUS POSTAGE & HANDLING FREE FOR ORDERS OVER \$150.00 \$5.95</p> <hr/> <p>TOTAL ORDER</p>
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