

# K-TEL MEDS LTD. **PRESCRIPTION MEDICATION ORDER FORM**

**Phone: Toll Free 1-866-583-5777**  
**Fax: Toll Free 1-866-583-5300**  
**email: info@ktelmeds.com**  
**website address www.k-telmeds.com**

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**I VERIFY THAT THE INFORMATION THAT I HAVE PROVIDED BELOW IS TRUE AND CORRECT.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Mailing address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ Phone (work) \_\_\_\_\_  
 Fax number \_\_\_\_\_ email Address \_\_\_\_\_

If you are unable to make a special visit to your doctor to get your prescription, call your doctor and ask him/her to fax the prescription directly to our pharmacy. Our toll free fax number is 1-866-583-5300. Then complete the forms and fax or mail them back to us. Please ask your doctor to print your name and address clearly and legibly on the prescription.

PLEASE INDICATE (WITH  A MARK) IF YOU WANT A:  
 1 MONTH SUPPLY \_\_\_\_\_ OR; 2 MONTH SUPPLY \_\_\_\_\_ OR; 3 \_\_\_\_\_ MONTH SUPPLY

**A Generic version of your medication may save you money. If you are interested please contact us for details and prices.**

Name of medication and strength	Qty	Price in US\$

Add \$15.00 shipping per order

Total for order \$ \_\_\_\_\_

**TURN OVER & COMPLETE**

**IMPORTANT;** The original physician's prescription, or copy of the prescription **MUST** accompany this order form. **We do not handle orders for controlled drugs, nor narcotics, etc.**

Medications are only available in the quantities shown. Packaging cannot be broken into smaller quantities.

I hereby confirm that I have been taking all the drugs ordered above for more than 30 days.

Patient counseling by the pharmacist is mandatory in Manitoba, Canada, regarding: what the drug does, how and at what time to take the drug, what to do if a dose is missed, common side effects, food, drink and other drugs or activities to avoid, special storage requirements, the importance of taking the drug regularly or as needed. Please specify below when it would be a good time for our pharmacist to contact you.

The best time of day to contact me is \_\_\_\_\_

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**Payment method:**  Mastercard or  Visa or  Money order  
or  Regular check (for orders under \$300.00)  
or  Certified check or Bank Draft (for orders over \$300.00)

**Checks and Money Orders made payable to K-tel.**

For payments by Credit Card please provide:

Name on Card \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Expiry Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**PLEASE PRINT CLEARLY**

Please phone us toll free, at **1-866-583-5777**, to give your credit card number if you prefer.

How did you hear about K-tel Meds Ltd.<sup>sm</sup>?

TV  Newspapers/Magazines  Friend/Relative  Website  Other \_\_\_\_\_