Pharmacy Discount
Affordable healthcare

ORDER FORM

PLEASE PRINT IN BLOCK CAPITALS

Mr/Mrs/Ms/Dr First Name _____

Last Name _____

Home Address _____

Suburb _____ Postcode _____

IF DELIVERY ADDRESS IS DIFFERENT FROM THE ABOVE ADDRESS THEN PLEASE FILL IN BELOW

Business Name _____

Delivery Address _____

Suburb _____ Postcode _____

Contact Phone number (We must have a phone number to process your order) Home ( ) _____

Work ( ) _____ Fax ( ) _____

Mobile_____ Email _____

PAYMENT METHODS

☐ Cheque/Money order for $_____

☐ Credit Card ☐ BANKCARD ☐ VISA

☐ MASTERCARD ☐ DINERS* ☐ AMEX*

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date___/___ Contact phone number ( )_____

Signature_____

Only signed orders can be accepted. Order will only be sent once funds have been cleared.

*Please Note: There is a 2.5% surcharge to use Amex or Diners

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.

Patient's full Name _____

Address *(if different to above)* _____

Suburb_____ Postcode _____

Date of birth ____/____/____ Sex M ☐ F ☐

Health Care Card/Pension Card/ Safety Net Entitlement Card.
You must include a photocopy of your card the first time you use us.

☐☐☐☐☐☐☐☐☐☐☐☐☐

Your Doctor's Name (optional)_____

Address _____

Suburb _____ Postcode _____

Doctor's Phone _____ Fax No _____

Medicare card number. Compulsory if ordering any NHS prescription. Fill all 11 boxes and expiry date. The last digit is the number next to the first name.

EXP DATE___/___ ☐☐☐☐☐☐☐☐☐☐☐

Please tick [✔] the appropriate box(es) below :

Do you have any drug allergies?

☐ No drug allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin
☐ Penicillin ☐ Sulfa ☐ Tetracycline
☐ Other – *please specify*_____

Do you have any of the following medical conditions?

☐ No chronic conditions ☐ Arthritis ☐ Asthma
☐ Diabetes ☐ Epilepsy ☐ Thyroid ☐ Stomach ulcers
☐ High blood pressure ☐ Glaucoma ☐ Heart condition
☐ Other condition – *please specify* _____

Are you on any other medication including non prescription medication?

Please specify _____

_____

CODE (if known)	NAME OF PRODUCT Please give full details of each product ordered	PATIENT NAME For ALL medicines ordered	QTY	PRICE$

Would you like us to substitute a less expensive equivalent brand if available and if your doctor permits? **YES** ☐ **NO** ☐

Do you require a receipt for your private health fund? **YES** ☐ **NO** ☐

Would you like us to keep your repeat prescriptions? **YES** ☐ **NO** ☐

SUBTOTAL	
PLUS POSTAGE & HANDLING FREE FOR ORDERS OVER $150.00	**$5.50**
TOTAL ORDER	