Read This First!

A Step by Step Guide to placing an order with Clayman Pharmacy

Step 1. Fill in your Medical History

Step 2. Read and sign the Patient Authorization

Step 3. Complete the Prescription Order

Step 4. Fax or Mail all your documents to Clayman Pharmacy:

Fax: 1-204-261-6390

Mail: 1-1099 Kingsbury Avenue
Winnipeg, MB, Canada R2P 2P9

Please check that you have included:

- ☐ *Medical History*
- ☐ *Patient Authorization*
- ☐ *Prescription Order with method of payment*
- ☐ *Prescriptions*

Step 5. Receive a call from Clayman Pharmacy confirming your order.

Step 6. Your first prescription arrives by mail within 3 to 4 weeks from the date of receiving your prescription order.
Refill information will be included with your order.

If at any time during this process you have any questions or need help, please contact us at: 1-877-CLAYMAN (252-9626) or info@claymanpharmacy.com

Medical History

1. Personal Information

Name: _____ **Birthday (mm/dd/yy):** _____/_____/_____ **Sex: M / F**
Address: _____

_____

Daytime Phone #: (_____) _____ -- _____ **Home Phone #:** (_____) _____ -- _____

2. Primary Physician Information

Name of Primary Physician: _____ **Phone #:** (_____) _____ -- _____
Address of Primary Physician: _____

_____

3. Personal Medical Information

Have you been diagnosed with...	*Please check one:*		
	Yes, in the Past	*Yes, Presently*	*No*
High blood pressure?			
Hypertension?			
Diabetes, thyroid or other endocrine disorder, including insulin resistance?			
Immune disorders?			
Poor immune healing?			
Edema or excessive fluid retention?			
Any known nutrition deficiency including minerals and electrolytes?			
Upper respiratory disorders?			
Renal or kidney disease?			
Liver disease?			
Orthopaedic or muscle disorder, including fracture, joint disorder, or carpal tunnel syndrome?			
Emotional disorders?			
Glaucoma?			
Rheumatoid arthritis, lupus, or connective tissue diseases?			
Chemical dependency?			
Cardiovascular (heart or artery) disease?			
Lipid (cholesterol) disorder, including hyperlipidemia (high cholesterol)?			
Migraine headache?			
Breast Cancer?			
Prostate Cancer?			
Other forms of Cancer? (if yes, specify _____)			
Any other illness, disease, medical condition or disorder? If yes, please specify below: (_____)			

Medical History (continued)

3. Personal Medical Information (continued)

Have you had a physical examination in the last 12 months by a physician? (Yes or No): _____
(Please note this is a precondition to being serviced by Clayman Pharmacy Inc.)

Are you allergic to any drugs? (Yes or No): _____
If yes, please specify: _____

Do you exercise regularly? (Yes or No): _____
If yes, please specify the type, frequency and duration: _____

Do you smoke? (Yes or No): _____ If yes, how many cigarettes per day? _____

Weight (lbs): _____ Height (ft' in"): _____

Are you pregnant? (Yes or No): _____
If yes, please indicate the number of weeks you are into the pregnancy: _____ weeks.

4. Family Medical Information

Do you have a Family History of …	*Please check one:* Yes	No
Diabetes, Thyroid or other endocrine disorder?		
Breast Cancer?		
Hypertension (high blood pressure)?		
Cardiovascular (heart or artery disease)?		
Lipid (cholesterol)?		
Prostate Cancer?		
Other forms of Cancer? (if yes, specify _____)		
Migraine Headaches?		
Any other illness, disease, medical condition or disorder? If yes, please specify below: (_____)		

5. Current Prescription and Non-Prescription Medication

Please list any prescription and non-prescription medication you are currently taking:

Name of Drug & Strength	Dose	Reason for Prescription	Duration Previously Taken

6. Agreement

I, _____ hereby affirm that all information herein contained is truthful and accurate.
(print name)

Signature: _____ Date: _____

IMPORTANT: All information collected by Clayman Pharmacy Inc., be it on this form or otherwise, is held in confidence, and kept and shared in accordance with the Personal Health Information Act of Manitoba, C.C.S.M. c. P33.5 and its associated regulations.

Patient Authorization

LIMITED POWER OF ATTORNEY, REPRESENTATION, AUTHORIZATION AND RELEASE FORM

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

The undersigned, (hereinafter the "Patient"):

1. Represents to Clayman Pharmacy Inc. (hereinafter "Clayman Pharmacy") the Patient is of the age of majority in the jurisdiction in which the Patient ordinarily resides ("Place of Residence").
2. Represents to Clayman Pharmacy the Patient is not restricted from making his or her own medical decisions under the laws of the Place of Residence of the Patient.
3. Confirms to Clayman Pharmacy that the pharmaceutical(s) ordered by the Patient ("the Ordered Medication") were prescribed by a duly qualified medical practitioner in the Place of Residence of the Patient ("The Patient's Doctor") only after a personal examination by the prescribing physician necessitating the need for the Ordered Medication(s) for the Patient's specific diagnosed medical condition.
4. Represents to Clayman Pharmacy that the Patient has been taking all Ordered Medication for at least a thirty (30) day period immediately prior to the date that the Patient submits his/her prescription to Clayman Pharmacy for filling.
5. Represents to Clayman Pharmacy that the Patient has not violated any laws in the Place of Residence of the Patient, in obtaining the prescription for the Ordered Medication.
6. Represents to Clayman Pharmacy that the Ordered Medication will not be used in any way whatsoever, except as prescribed by the Patient's Doctor and that the duty of care is the responsibility of the Patient's Doctor.
7. Represents to Clayman Pharmacy that no person other than the Patient will use the Ordered Medication.
8. Represents to Clayman Pharmacy that if the Patient sends any prescription, or a copy of any prescription, to Clayman Pharmacy the Patient has not already filled said prescription, and will not fill said prescription without prior notification to Clayman Pharmacy.
9. Represents to Clayman Pharmacy that the Patient has completely and accurately completed the attached *Patient Medical History Form*.
10. Represents to Clayman Pharmacy that the Patient did not seek or request a medical opinion of the Canadian licensed co-signing physician regarding the strength, dosage, usefulness or qualities of the Ordered Medication or the duration of use, frequency of use, or appropriateness for their particular medical condition, nor does the Patient seek any medical advice in any way from the Canadian co-signing physician.
11. Releases the Canadian co-signing physician from any obligation to conduct a personal physical examination of the Patient and acknowledges that the Patient's Doctor has conducted a personal physical examination of the Patient within a twelve (12) month period immediately prior to the date on this form.
12. Authorizes the Patient's Doctor to release any and all medical information and data to Clayman Pharmacy that Clayman Pharmacy shall request for the purpose of performing a medical review to determine whether the medication prescribed by the Patient's Doctor is appropriate in the circumstances, and further grants permission to Clayman Pharmacy to review such information and data for the same purpose.
13. Releases and discharges any Canadian physician engaged by Clayman Pharmacy to review the prescription for appropriateness to be lawfully issued in Canada as directed by the Patient's Doctor from any and all liability, claims ro causes of action with respect to the use or application of the Ordered Medication by the patient, including, but not limited to, undesired side effects.
14. Authorizes Clayman Pharmacy to not use child protective packaging.
15. The Patient releases and discharges Clayman Pharmacy and all of their officers and directors, agents and employees from any and all causes of action with respect errors or omissions by the company or agency responsible for transporting the Ordered Medication to the Patient.

PLEASE TURN OVER ›

PATIENT AUTHORIZATION (CONTINUED)

16. Agrees to pay Clayman Pharmacy either by, 1) an international postal money order, or 2) a Visa, American Express, Discover or Mastercard credit card. Furthermore, the Patient agrees that if the Patient opts to pay by credit card, then the credit card provided at the time an order is made will either, 1) be in the Patient's name, in which case Clayman Pharmacy is authorized to charge to the credit card the full amount owing by the Patient for the Ordered Medication, or 2) be in the name of another individual, in which case a letter authorizing Clayman Pharmacy to charge to the credit card the full amount owing by the Patient for the Ordered Medication must be signed and dated by the cardholder and sent to Clayman Pharmacy. The Patient acknowledges that prior to Clayman Pharmacy shipping any Ordered Medication, either the international postal money order must be received, or the credit card provided by the Patient at the time the order is placed must be valid and the full charge of the Ordered Medication be accepted by the appropriate credit card institution.
17. Grants Limited Power of Attorney to Clayman Pharmacy, for the limited purpose of signing any documents as required by the laws and regulations of the Province of Manitoba and/or the Country of Canada, which are necessary to permit the delivery of the Ordered Medication to the Patient, in the same manner as the Patient could, if the Patient had personally attended at Clayman Pharmacy's place of business.
18. Attorns to the jurisdiction of Manitoba and agrees that any dispute that arises between the Patient and Clayman Pharmacy shall be heard by the courts in Manitoba, Canada. The Provider and Patient hereby submit to the jurisdiction of Manitoba and agree that any dispute shall be heard by the Courts in Manitoba, Canada, including, but not limited to any claims of negligence and/or malpractice. Further, the Patient agrees that the laws of Manitoba, Canada shall apply in such a proceeding, agrees to these provisions on the basis that the Patient understands that he/she is actively doing business in Manitoba, Canada pursuant to the laws, policies and privileges of Canadian law including but not limited to the laws of Manitoba, Canada and that the Patient is benefiting from such laws, policies and privileges by participating in this program.
19. Acknowledges to Clayman Pharmacy that the Patient is aware that the Ordered Medication may not be returned for a refund or an exchange.

Be advised that, given the international nature of the practice of International Prescription Service (IPS) pharmacy, there may be limitations in the ability of the Manitoba Pharmaceutical Association (MPHA), which is the statutory licensing authority for pharmacies and pharmacists in the province of Manitoba, to investigate and prosecute complaints from persons who receive services or products from an IPS pharmacy.

Manitoba pharmacists are not permitted to fill US physicians' prescriptions. They can only fill prescriptions issued by a physician licensed in a province or territory of Canada. MPHA takes the position that it may be contrary to professional standards for a pharmacist to fill prescriptions by a physician, licensed in a province or territory of Canada, who has not established an acceptable patient-physician relationship with you.

By signing below the Patient confirms that:
a) all the information presented in the Patient Medical History Form is true and correct, and
b) the Patient has read and understood the nineteen (19) terms which make up the Limited Power of Attorney, Representation, Authorization, and Release Form, and that the Patient agrees that the terms herein are binding on the Patient and Clayman Pharmacy, and their respective assigns, estate administrators, heirs, successors, and personal representatives.

Name: _____ Signature: _____ Date: _____

IMPORTANT: All information collected by Clayman Pharmacy Inc., be it on this form or otherwise, is held in confidence, and kept and shared in accordance with the Personal Health Information Act of Manitoba, C.C.S.M. c. P33.5 and its associated regulations.

QUESTIONS? PLEASE CALL US AT 1-877-CLAYMAN (252-9626) OR FAX US AT 1-204-261-6390
EMAIL US: INFO@CLAYMANPHARMACY.COM WWW.CLAYMANPHARMACY.COM

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Rx New Patient Prescription Order

To place an order you will need to return this completed form with a current prescription and a valid method of payment.

1. Patient Information

Name of Patient(s): _____

Address of Patient(s): _____

_____

2. Payment Information

I will be paying for the following prescriptions by:

☐ **International postal money order** (*must be enclosed with this form*)

OR

☐ **Credit Card** (*select one*):

Visa _____ American Express _____

Discover _____ Mastercard _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Name on Credit Card: _____

Signature on Credit Card: _____

3. Order Information

There are a total number of ____ prescriptions with this order. Please list them in the table below.
If you have more than 5 prescriptions, please attach their information on a separate sheet.
We will be happy to fill up to a 3 month supply of each prescription.

	Name of Drug and Strength	Number of Pills Requested	Initial
1			
2			
3			
4			
5			

Please include these prescriptions with this order.

Name: _____ Signature: _____ Date: _____

Your order will be confirmed by telephone prior to being processed.

Questions? Please call us toll free at 1-877-735-7271 or 1-877-CLAYMAN or fax us at 1-204-261-6390