JANDRUGS.CA PRESCRIPTION FORM

Toll Free: 1-866-395-3784 - **Fax:** (204) 928-2039
210-530 Kenaston Blvd. Winnipeg, MB, Canada R3N 1Z4

PRESCRIBER INFORMATION

Prescriber ______________________
Address ______________________
City, Province, Postal Code ______________________
Lic. # ______________________
Phone Number ______________________
FAX Number ______________________

PATIENT INFORMATION

Patient Name ______________________
Patient Date of Birth ______________________
Patient Address ______________________
Patient Telephone ______________________
Patient Allergy ______________________
Patient Medical Number ______________________

COMPOUNDING INFORMATION

Compounded Medication ______________________
Chemical Name ______________________ **Strength** ________ **% or** ________ **mg**
Chemical Name ______________________ **Strength** ________ **% or** ________ **mg**
Chemical Name ______________________ **Strength** ________ **% or** ________ **mg**
In Formulation Solution/suspension/lozenge/lollipop/suppository/cream/ointment/transdermal ointment/transdermal cream/transdermal gel/rapid dissolve tablet/effervescent powder/sublingual

Other____

Qty. ______________________
Mitte ______________________
Refill ______________________

DOCTOR'S INFORMATION

Doctor's Name ______________________
Doctor's Signature ______________________
Lic. # ______________________
Date / Time ______________________

TO THE PHARMACY REGARDING CERTIFICATION

- This prescription represents a true ORIGINAL prescription drug order.
- The addressee noted above is the only intended recipient and there are no others.
- The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.

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