TULE RIVER & TREDC
CANADIAN PRESCRIPTION PROGRAM

GHM Canada
78 Haven Hurst Cres Sw
Calgary, AB T2V 3C5 Canada

OUR SPECIAL OFFERS

- **$0 Co-Pay**
- **No Membership fees.**
- **Speak to a live person**
- **Safe and affordable**

We invite you to use our Canadian pharmacy partner to fill your 90-day supply of maintenance medications!

- Our Guarantee: Fulfillment from Government Registered Pharmacies, Owned and operated by Government Licensed Pharmacists, providing Government inspected prescriptions.

How it works:

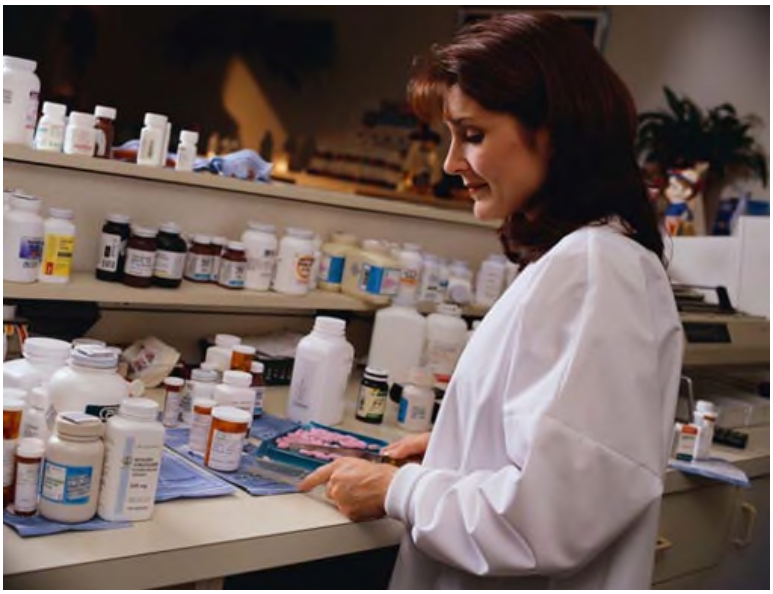
1. Contact our Client Services Manager Becki Stabbler toll free to enroll over the phone: 1-888-303-5255

2. Or Fill out the patient health profile

3. Have your doctor fax in your prescription to our toll-free prescription line (We can also contact your doctor for your prescription)

4. Once we receive your prescription our Pharmacist and medical staff will review

5. We will then process and ship a 90-day supply of your maintenance medication directly to your home or office



IMPORTANT CONTACT INFORMATION

Client Services Manager: Becki Stabbler
Toll free Phone: 1-888-303-5255
Toll Free Fax: 1-877-334-6737
Email: becki.stabbler@ghmcanada.com

- ***Our Pharmacists are available for direct consultation with our clients, at no charge**

HEALTH HISTORY QUESTIONNAIRE

For questions please call: 1-888-303-5255 or Cellular: 1-905-716-9008
A form of ID is required.
Fax: 1-877-334-6737
Email: becki.stabbler@ghmcanada.com
Mailing address: 78 Havenhurst Crescent SW, Calgary, AB T2V 3C5

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please fill out all requested information.

Name (Last, First, M.I.):	☐ **M** ☐ **F**	**DOB:**	
Address:			
Day Phone:		**Evening Phone:**	
Height:		**EMAIL**	
Weight		**AUTOMATIC REFILLS (Y/N)**	
Accept Medication from our Overseas Pharmacies? (Y/N)		**Accept Generic Medications (Y/N)**	
Date of last physical exam:		**Pregnant (Y/N) / Due Date / Nursing (Y/N)**	

PERSONAL HEALTH HISTORY

List any medical problems that have been diagnosed

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

DOCTOR INFORMATION

PRIMARY PHYSICIANS

NAME:_____
PHONE:_____
FAX#:_____

ADDITIONAL PHYSICIANS

NAME:_____
PHONE:_____
FAX#:_____

ADDITIONAL INFORMATION