

## WHY CHOOSE NATIONAL PHARMACY?

National Pharmacy is a Canadian owned company. It was founded over 30 years ago with the goal of providing the best possible care to retirement home communities. National Pharmacy recognized the need for specialized geriatric pharmacists and now National Pharmacy is one of the fastest growing pharmacy services in Ontario.

National Pharmacy has made significant investment in employing the best Clinical Consultant Pharmacists, including Certified Geriatric Pharmacists, Registered Technicians and Pharmacy assistants to ensure exceptional pharmaceutical care and the highest possible service levels.

National Pharmacy provides services to all residents including those who are self medicating.

National Pharmacy prides itself on its ability to tailor its services to meet the needs of each resident it services.

All services and procedures can be modified to meet your specific requirements. Our services are continually evolving as the health-care industry changes and technology advances. We are confident that our experience, advanced systems, procedures, and our ability to cater our service offering to each retirement community will enable us to provide outstanding service.

Interested in taking advantage of our services? Please fill out the prescription transfer form found below. Please give the form to one of the nurses to fax to the pharmacy.

Any questions or concerns please feel free to contact us. Contact: Your Pharmacy Care Team E-mail:info@nationalpharmacy.ca

Toll Free: 1-877-265-8365 Toll Free Fax: 877-265-5524

## Why should you switch to National Pharmacy?

- ✓ No fee pharmacy transfer
- ✓ No fee prescription delivery daily/weekly
- ✓ Price matching from your current pharmacy for self medicating residents (same packaging as previous pharmacy.
- Personal visits by trained Pharmacist
- ✓ to review medication history
- ✓ Customer Satisfaction Guaranteed

I hereby give permission to National Pharmacy to contact my current pharmacy for the purpose of transferring my prescriptions

Name (Please Print):	Private Insurance Yes or No
Date of Birth:	If yes, name
Phone Number:	D1 "
Signature:	Member Id#:
Pharmacy:	
Phone Number:	
Address:	
Audi 633.	

<sup>\*\*</sup>Please attach copy of previous pharmacy receipt for price matching.