



CardinalHealthCanada



NestléHealthScience

NOURISHING PERSONAL HEALTH

Pre-Surgical Optifast® Order Form

IF COMPLETING MANUALLY, PLEASE WRITE CLEARLY

Date: _____

PATIENT DETAILS:

Dr. _____ of the _____ clinic

has prescribed **Optifast® 900** for (Patient Name): _____

Date of Surgery: _____ Doctor's Phone: _____

Delivery Address: _____

Postal Code: _____ Phone: _____

Special Delivery Instructions: _____

for a:

- 2-Week Protocol = 4 inner boxes (\$152.00)
- 3-Week Protocol = 6 inner boxes (\$228.00)
- 4-Week Protocol = 8 inner boxes (\$304.00)

Other: _____

Flavour: _____ x Chocolate Inner Cartons NN9521565 _____ x Vanilla Inner Cartons NN9521564

PAYMENT DETAILS:

- Billing information below
- Patient will call with billing information 1-866-830-6046

BILLING INFORMATION:

- Visa
- Mastercard
- American Express

Card #: _____ Expiry: _____

Name on card: _____

Signature: _____

E-MAIL ORDERS TO: optifastdirectorders@cardinalhealth.ca

FAX ORDERS TO: 1-866-892-2890