

Doctor's name: _____ Surgery name: _____

Surgery address: _____

Your doctor has recommended that you take RINAR for the treatment of non-allergic rhinitis (NAR). Further information about NAR and RINAR is provided in the information booklet you will receive with your order, or you can visit our website at www.rinar.com.au

Order Information

Name: _____

Delivery address: _____

Postcode: _____

To help us contact you about your order please provide the following information:

Mobile: _____ Email: _____

Payment type (please tick): M/card VisaCard number: CVN number Exp ____/____

Cost \$45.00 (Include Postage and handling)

Quantity: _____ Total amount to be billed: _____

Cardholder signature: _____

Please fax this completed order form to iNova Pharmaceuticals on 1800 651 454 or email to customer.service@inovapharma.com For more information please visit our website www.rinar.com.au or phone us on 1300 363 212.

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