NEW PRESCRIPTION ORDER FORM

Bayview Pharmacy

1 Patient Information *** For Terminally Ill Hospice Patient***

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F		Email

2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

Rx **Prescribing Form – Non-Sterile Hospice Compounded Medication**

○ **Stanford Modified Mouthwash**

Directions/SIG

- ○ Swish and spit 5 mL every 4 hours as needed for mouth pain.
- ○ Swish 5 mL for 30 seconds every 6 hours; spit after use.
- ○ Swish and spit 5 mL before meals and at bedtime as needed.
- ○ Other _____

_____

Quantity _____ **Refills** _____

X_____ _____

Prescriber's Signature Date

3 Fax it to Bayview Pharmacy at (401) 284-4506 or to our alternative fax (401) 210-2757.