

# NEW PRESCRIPTION ORDER FORM

## 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                                             | Email        |        |
|                            |       | <input type="radio"/> M <input type="radio"/> F |              |        |

## 2 Prescriber and Prescription Information

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



### Prescribing Form – Non-Sterile Hospice Compounded Medication

☐ Oxycodone HCl 30 mg Suppository

#### Directions/SIG

- ☐ Insert 1 suppository rectally every 4–6 hours as needed for pain.
- ☐ Insert 1 suppository every 6 hours on a scheduled basis.
- ☐ Insert 1 suppository every 4 hours for severe pain.
- ☐ 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.