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

○ Morphine Sulfate 1 mg/mL Oral Suspension

Directions/SIG

○ Give 5–10 mL by mouth every 3 hours as needed for pain or shortness of breath.

○ Give 5 mL every 4 hours as needed; may titrate based on comfort.

○ Give 10 mL every 4 hours; use 5 mL for mild symptoms.

○ 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.