

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

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

☐ Ondansetron 4 mg/0.1 mL Topical Cream

Directions/SIG

- ☐ Apply a small amount to the inner wrist or forearm every 6 hours as needed for nausea.
- ☐ Apply a thin layer every 8 hours; may repeat once after 30 minutes for breakthrough symptoms.
- ☐ Apply a small amount every 12 hours as needed for nausea.
- ☐ 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.