

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	

RX

Prescribing Form – Non-Sterile Hospice Compounded Medication

- Nifedipine 0.2% Rectal Gel

Directions/SIG

- Apply a small amount rectally every 12 hours.
- Apply twice daily for anal fissure discomfort.
- Apply every 8–12 hours as needed for 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.