

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

☐ Morphine Sulfate 2% Oral Rinse

Directions/SIG

- ☐ Swish and spit 5 mL every 4 hours as needed for severe mucositis pain.
- ☐ Swish 5 mL for 1 minute every 6 hours; spit after use.
- ☐ Swish 5 mL before meals for eating-related 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.