

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

- Lorazepam 5 mg/g Topical Cream

Directions/SIG

- Apply a thin layer to chest or wrist every 6 hours as needed for anxiety.
- Apply to inner wrist three times daily.
- Apply a small amount every 4–6 hours for breakthrough anxiety.
- 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.