

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

☐ Misoprostol 0.0024% / Phenytoin 5% / Gentamicin 0.2% Gelt

Directions/SIG

- ☐ Apply a thin layer to the wound twice daily.
- ☐ Apply every 12 hours; may cover with dressing.
- ☐ Apply to wound bed once daily and as needed for drainage.
- ☐ 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.