

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

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.