

# 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 2% / Beta Glucan 0.5% Gel

#### Directions/SIG

- Apply a thin layer to the affected area daily and as needed.
- Apply twice daily for wound healing support.
- Apply every 12 hours; cover with a light dressing if needed.
- 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.