

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

- Lidocaine HCl 2% Oral Rinse

Directions/SIG

- Swish and spit 5 mL every 4 hours as needed for pain.
- Swish 5 mL for 30 seconds every 6 hours; spit after use.
- Swish and spit 5 mL before meals for chewing or swallowing 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.