

# 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

☐ 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.