NEW PRESCRIPTION ORDER FORM

Bayview Pharmacy

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 ○ M ○ 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

○ **Ketamine HCl 2% / Morphine Sulfate 2% Topical Foam**

Directions/SIG

- ○ Apply a small amount of foam to the painful area every 6 hours as needed.
- ○ Apply to affected area three times daily for pain control.
- ○ Apply a thin layer every 4–6 hours for severe allodynia or mixed 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.