

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

- Glycopyrrolate 2% Topical Foam

Directions/SIG

- Apply a small amount of foam to the neck or chest every 6-8 hours as needed for excess secretions.
- Apply a thin layer every 6 hours; may repeat once after 30 minutes.
- Apply twice daily and as needed for secretion management.
- 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.