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	

Rx

Prescribing Form – Non-Sterile Hospice Compounded Medication

○ **Glycopyrrolate 0.1 mg/0.25 mL Topical Cream**

Directions/SIG

- ○ Apply a pea-sized amount to the neck or chest every 4–6 hours as needed for secretions.
- ○ Apply a thin layer to the neck every 6 hours for secretion control.
- ○ Apply a small amount every 8 hours as 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.