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

○ **Diazepam 10 mg/g Vaginal/Rectal Gel**

Directions/SIG

- ○ Apply 1 g rectally or vaginally at onset of seizure activity.
- ○ Apply 1 g rectally as needed for seizure clusters; may repeat once after 10 minutes.
- ○ Apply 0.5–1 g rectally or vaginally every 6 hours as directed for seizure control.
- ○ 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.