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

○ **Hydrocodone Bitartrate 10 mg/5 mL / Acetaminophen 325 mg/5 mL Oral Suspension**

Directions/SIG

- ○ Give 5 mL by mouth every 4–6 hours as needed for pain.
- ○ Give 2.5–5 mL every 6 hours as needed; do not exceed 6 doses per day.
- ○ Give 5 mL every 6 hours; may use 2.5 mL for mild 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.