# 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**

○ **Lidocaine HCl 1% / Diphenhydramine HCl 2% / Dexamethasone 0.5% / Cimetidine 4% Topical Cream**

**Directions/SIG**

- ○ Apply a thin layer to affected area every 6 hours as needed for itching.
- ○ Apply to itchy area three times daily.
- ○ Apply a small amount every 4–6 hours for relief.
- ○ 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.**