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

○ **Lorazepam 1 mg/mL / Diphenhydramine HCl 12.5 mg/mL / Haloperidol 2 mg/mL / Metoclopramide 20 mg/mL Topical Cream**

Directions/SIG

- ○ Apply 0.5–1 mL to the inner wrist or forearm every 6 hours as needed for nausea or vomiting.
- ○ Apply 1 mL every 6 hours; may apply an additional 0.5 mL once after 30 minutes for breakthrough nausea.
- ○ Apply 1 mL to the inner wrist every 4–6 hours as needed for nausea, vomiting, or refractory symptoms.
- ○ 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.