

# NEW PRESCRIPTION ORDER FORM

## 1 Patient Information

Last Name		First Name		MI
Address				Apt. #
City	State	ZIP	Phone Number	
Date of Birth (mm/dd/yyyy)		Sex	Email	
		<input type="radio"/> M <input type="radio"/> F		

## 2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number		Fax Number
Street Address		
City	State	ZIP
NPI	DEA	



### Prescribing Form – Compounded Medication

☐ Progesterone 200 mg Capsules (Gluten Free/Peanut Oil Free)

### Directions/SIG

- ☐ Take 1 capsule by mouth once daily at bedtime.
- ☐ Take 1 capsule by mouth twice daily as directed.
- ☐ Take 1 capsule by mouth every evening for hormone support.
- ☐ Other \_\_\_\_\_

### Quantity

- ☐ 30 caps   ☐ 60 caps   ☐ 90 caps   ☐ Other \_\_\_\_\_

### Refills

\_\_\_\_\_

X \_\_\_\_\_

Prescriber's Signature

\_\_\_\_\_ Date

## 3 Fax it to Bayview Pharmacy at (401) 284-4506 or to our alternative fax (401) 210-2757.

We are currently licensed to service patients residing in **RI, MA, CT, NY, NJ, NH, and FL.**

Unfortunately, we are unable to fulfill prescriptions for patients outside of our service area.