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 ○ M ○ F		Email

2 Prescriber and Prescription Information

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

℞

○ Sodium Acetate/Sodium Propionate/Sodium Butyrate
____ - ____ - ____ MM (60ml dose) Enema
Typical Strength is 60-30-40

○ Other _____

Directions: ○ Insert contents of enema bottle once daily

○ Other _____

QTY: _____

Refills: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Other: _____

X_____ _____
Prescriber's Signature Date

3 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

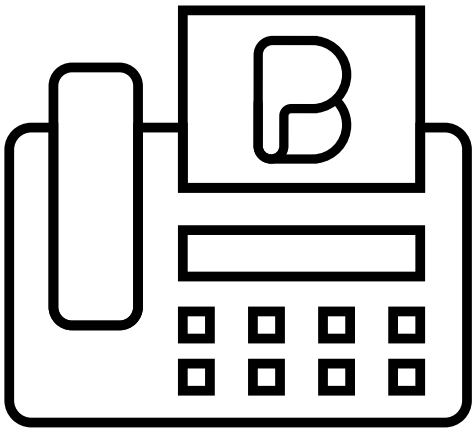
_____ _____
Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

Bayview Pharmacy

Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

www.bayviewrx.com