

Fountain Valley Medical Center Pharmacy Oral Mucositis Order Form

Fax completed form via fax at 714-979-0532 or email at fountainvalleyrx@outlook.com

Patient Information		Prescriber Information	
Patient Name: _____	DOB: _____	Prescriber: _____	
Street Address: _____		NPI#: _____	DEA#: _____
City/State/Zip: _____		Street Address: _____	
Phone: _____	Email: _____	City/State/Zip: _____	
Allergies: _____		Phone: _____	FAX: _____
Insurance ID: _____			
BIN: _____	CARRIER: _____		
GROUP: _____	PCN: _____		

MEDICATION ORDER	
Oral Mucositis	Gelclair Oral Gel (oral mucosal barrier) QTY: 90 packets (1350 mL) Refills: _____ Sig: Rinse, gargle and spit contents of 1 packet (15ml) mixed in water three times daily as needed. Avoid eating or drinking for at least 30 minutes after use.
	Lidocaine 2%, viscous solution (topical oral anesthetic) QTY: 100ml x _____ Refills: _____ Sig: Rinse, gargle and spit 15 ml every 4 to 6 hours as needed for oral pain.

Prescriber's Signature: _____

Date: _____

Download Fillable forms on our website at www.fvmcp.com in the Forms section

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee, and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and phone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.
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