  
**PRESCRIPTION FOR PASTEURIZED DONOR HUMAN MILK (PDHM)**

**Healthcare Providers:**You can use your own prescription forms. Please include all the information listed below. Fax prescription to Mothers’ Milk Bank Northeast at **617-527-1005.**

**TO BE COMPLETED BY HEALTHCARE PROVIDER,**

**THEN FAXED TO MMBNE**

Baby’s Name:

Today’s Date:

DOB:

**Please provide ad lib amounts of PDHM for** \_\_\_\_\_\_\_ weeks (1 to 4) \_\_\_\_\_\_\_ months (1 to 12) for the following reasons:

☐ Prematurity *(P07.3)* ☐ Small for Gestational Age (SGA) *(P05.1)* ☐ LPI *(P07.39)*   
☐ Slow feeding *(92.2)* ☐ Cleft Lip *(Q36)* ☐ Cleft Palate *(Q35.9)* ☐ Failure to Thrive *(P92.6)* ☐ Hypoglycemia (*P70.4)* ☐ Adoption *(Z02.82)*  
☐ Intrauterine Growth Restriction (IUGR) *(P05.9)* ☐ Feeding Issue, non. Spec (*P92.9)* ☐ NAS *(P04.49)*  
☐ Difficulty feeding at the breast *(P92.5)* ☐ Maternal Health Complications *(092.79)* ☐ Multiple Gestation (O*30)*   
☐ GI issues *(0-28 days: P92.9) (after 28: R63.3)* ☐ Hyperbilirubinemia *(P59.9)* ☐ Abnormal Weight loss *(R63.4)* ☐ Non-lactating parent ☐ Other feeding intolerance

Provide details here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Healthcare Provider**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name or Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Healthcare Providers:*** *for questions contact the Director of Client Relations,*

*617-527-6263 (ext. 7).*

**Parents/Guardians**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Parents/Guardians:*** *to set up an account to order milk, contact* [*orders@milkbankne.org*](mailto:orders@milkbankne.org)

*or 617-527-6263 (ext. 4).*

9/3/21 AS