TO BE COMPLETED BY HEALTHCARE PROVIDER, THEN FAXED TO MMBNE

Mothers' Milk Bank Northeast

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.**

Baby's Name:	DOB:	Today's Date:

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

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

Provide details here: _____

_____

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