



OUTPATIENT REQUEST FOR PASTEURIZED DONOR HUMAN MILK AT LEGACY SALMON CREEK APOTHECARY



2121 N.E. 139th St., Medical Office Building A Suite 310, Vancouver, WA 98686
Phone: 360-487-3700 • Fax: 360-487-3709
Hours: Monday-Friday 9 a.m. – 6 p.m.
Closed weekends and holidays

Today's Date: _____ Infant Name: _____ Infant DOB: _____

Parent Name(s): _____

Primary Phone Number(s): _____

Email (for receipts): _____

Street Address: _____ Apt. or Unit: _____

City: _____ State: _____ ZIP: _____

PRESCRIPTION

Medical Necessity: *(Select appropriate diagnosis for infant or mother)*

Infant Diagnosis:

- | | |
|--|--|
| <input type="checkbox"/> P92.2: Slow feeding of newborn | <input type="checkbox"/> P92.6: Failure to thrive in newborn |
| <input type="checkbox"/> P92.5: Neonatal difficulty in feeding at breast | <input type="checkbox"/> Q38.1: Ankyloglossia |
| <input type="checkbox"/> P92.9: Feeding problem of newborn | <input type="checkbox"/> Q38.5: Congenital Malformations of palate |
| <input type="checkbox"/> P59.0: Neonatal jaundice associated with preterm delivery | <input type="checkbox"/> R63.4: Abnormal weight loss |
| <input type="checkbox"/> P59.9: Neonatal jaundice, unspecified | <input type="checkbox"/> R63.6: Underweight |
| <input type="checkbox"/> P74.2: Dehydration of newborn | <input type="checkbox"/> P92.1: Bilious vomiting of newborn |
| <input type="checkbox"/> Preterm (gestation) _____ | <input type="checkbox"/> P92.09: Other vomiting in newborn |
| | <input type="checkbox"/> NICU admit – Days in NICU: _____ |

Maternal Diagnosis:

- | | |
|--|---|
| <input type="checkbox"/> O92.5: Suppressed lactation | <input type="checkbox"/> O92.3: Agalactia |
| <input type="checkbox"/> O92.4: Hypogalactia | <input type="checkbox"/> O92.70: Impaired milk production |
| <input type="checkbox"/> Z21: HIV (in mother) | |

DIRECTIONS:

Give _____ mL's 8-12 times a day as needed for supplementation.

The Outpatient will receive up to 18 oz (540 mL's) of donor milk per order. *(select # of refills)*

- No refills (total 18 oz)** **1 refill (total 36 oz)** **2 refills (total 54 oz)**

Exp. date: 4 weeks from date of issuance OR when the specific amount listed above has been filled.

Clinic or Hospital: _____ **Phone:** _____ **Fax:** _____

Prescribing Physician (print): _____

Physician Signature:

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN

***Human Milk is a limited resource and will be distributed based on availability. ***
***Family must call Salmon Creek Apothecary to place an order before arrival. ***