



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



2121 N.E. 139<sup>th</sup> 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 20 oz (600 mL's) of donor milk per order. *(select # of refills)***

- No refills (total 20 oz)       1 refill (total 40 oz)       2 refills (total 60 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. \*\*\*