OUTPATIENT REQUEST FOR PASTEURIZED DONOR HUMAN MILK AT LEGACY EMANUEL OUTPATIENT APOTHECARY

501 N. Graham St., Medical Office Building 2, Atrium, Portland, Oregon 97227
Phone: 503-413-4225 ● Fax: 503-413-4515
Hours: Monday-Friday 9 am – 6 pm, Saturday-Sunday 9 am – 5 pm (closed for lunch 1-1:30 pm)

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:

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

Maternal Diagnosis:

- ❑ O92.5: Suppressed lactation
- ❑ O92.4: Hypogalactia
- ❑ Z21: HIV (in mother)
- ❑ O92.3: Agalactia
- ❑ O92.70: Impaired milk production

DIRECTIONS:

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

Milk Order quantity:

- ☐ **270 mL (9 oz)**
- ☐ **540 mL (18 oz)**

# of refills

- ☐ **No refills**
- ☐ **1 refill (total 18 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: _____ _____

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