

PRESCRIPTION FORM FOR PASTEURIZED DONOR HUMAN MILK (PDHM)



Healthcare providers: Fax or email prescription to Human Milk Repository of New Mexico
Fax: 505-508-5428 Email: natalie@mothersmilkbanknm.org

BABY'S NAME: _____ DOB: _____ GA: _____

Today's date: _____

Please provide _____ oz/day amounts of PDHM for _____ days/weeks/months (circle one) for the following reasons:

- | | |
|--|---|
| <input type="checkbox"/> Z39.1 Encounter for lactation | <input type="checkbox"/> P92.2 Slow feeding of newborn |
| <input type="checkbox"/> 07.32 Prematurity | <input type="checkbox"/> P92.3 Underfeeding of newborn |
| <input type="checkbox"/> O92.3 Agalactia | <input type="checkbox"/> P92.5 Neonatal difficulty in feeding at breast |
| <input type="checkbox"/> O92.4 Hypogalactia | <input type="checkbox"/> P92.6 Failure to thrive in newborn |
| <input type="checkbox"/> O92.5 Low Milk Supply/ Suppressed Lactation | <input type="checkbox"/> P92.8 Other feeding problems of newborn |
| <input type="checkbox"/> O92.7 Unspecified disorders of lactation | <input type="checkbox"/> P92.9 Feeding problem of newborn, unspecified |
| <input type="checkbox"/> Z02.82 Adopted Child | <input type="checkbox"/> P59.9 Hyperbilirubinemia |
| <input type="checkbox"/> O30.0 Twin Pregnancy | <input type="checkbox"/> P70.4 Hypoglycemia |
| <input type="checkbox"/> O30.1 Triplet Pregnancy | <input type="checkbox"/> Q383.1 Frenulum Restriction |
| <input type="checkbox"/> P92.0 Vomiting of newborn | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> P92.1 Regurgitation and rumination of newborn | |

Healthcare provider:

Signature: _____

Name: _____

NPI# _____

Phone number: _____

Practice Name or Hospital: _____

Address: _____

Parents/Guardians:

Name: _____

Address: _____

Phone: _____

Email: _____

Parents/Guardians: to set up an account to order milk, contact Natalie Swart, Donor Coordinator at 505-508-5291 or natalie@mothersmilkbanknm.org