Breast Pump Order

Medical Need (aka Hospital Grade) Rental Pump or Personal Use Pump

MilkWorks
LINCOLN • OMAHA • YORK

Mother's Name _____

Infant's Name _____ Date of Order: ____ / ____ / ____

*Please indicate whether breast pump order is for a **Medical Need** (aka Hospital Grade) Rental Pump or a **Personal Use** Double Electric Pump. Thank you!*

_____ **RX: Hospital Grade Rental Pump** due to the following **Medical Need(s):**

DIAGNOSIS	**and**	**Length of rental MUST be indicated**
☐ Latch Difficulties	➔	up to_____months
☐ Hyperbilirubinemia	➔	up to_____months
☐ Inadequate Milk Supply	➔	up to_____months
☐ Infant/neonate w/ Abnormal Weight Loss	➔	up to_____months
☐ Infant Food Allergy	➔	up to_____months
☐ Mastitis	➔	up to_____months
☐ Prematurity: weeks gestation_____	➔	up to_____months
☐ Neurologic Abnormality (Infant) Specify condition _____	➔	up to_____months
☐ Congenital Abnormality of Infant Specify condition _____	➔	up to_____months
☐ Acutely ill Infant Primary diagnosis_____	➔	up to_____months
☐ Maternal Postpartum Complications Specify condition _____	➔	up to_____months
☐ Maternal Medical Condition Specify condition _____	➔	up to_____months

_____ **RX: Personal Use Double Electric Breast Pump**

Provider/Physician Signature: _____

If mother or baby have Medicaid coverage, this order must be signed by a physician. If mother has private insurance, a CNM, PA or APRN may sign.

Provider/Physician Name (printed): _____

Creating a healthier community by helping mothers breastfeed their babies – since 2001.

5930 South 58th, Ste W, Lincoln (402.423.6402) | 10818 Elm Street, Omaha (402.502.0617)
www.milkworks.org