HOSPITAL GRADE RENTAL BREAST PUMP ORDER

Patient's Name _____

Phone Number _____ DOB _____

Address _____

Infant's Name _____ DOB _____

TRICARE --- Sponsor SSN/Patients DBN: _____

RX Medical Need Rental Breast Pump

E0604 Breast Pump Device, Electric

Z39.1 - Encounter for the care and examination of lactating mother

DIAGNOSIS	LENGTH OF RENTAL
☐ Latch Difficulties	up to _____ months
☐ Prematurity Weeks Gestation _____	up to _____ months
☐ Congenital Abnormality of Infant Specify Condition _____	up to _____ months
☐ Neurological Abnormality of Infant Specify Condition _____	up to _____ months
☐ Mastitis	up to _____ months
☐ Hyperbilirubinemia	up to _____ months
☐ Inadequate Milk Supply	up to _____ months
☐ Infant Food Allergy	up to _____ months
☐ Abnormal Weight Loss of Infant	up to _____ months
☐ Low Birth Weight Birth Weight _____	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

Provider's Signature _____ Date: _____

Provider's Name (printed) _____

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