Breast Pump Order

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

Mother's Name _____

Infant's Name _____ Date of Order: _____

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

☐ RX: Medical Need (Hospital Grade) Rental Pump (E0604)

DIAGNOSIS	and	Length of rental MUST be indicated
☐ Latch Difficulties	➔	up to_____months
☐ Prematurity: Weeks gestation_____	➔	up to_____months
☐ Congenital Abnormality of Infant Specify condition _____	➔	up to_____months
☐ Neurologic Abnormality (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
☐ Infant/neonate w/ Abnormal Weight Loss	➔	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 (E0603)

Provider/Physician Signature: _____

If mother or baby have TriCare or Nebraska 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.

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