PROVIDER PRESCRIPTION

PASTEURIZED DONOR HUMAN MILK

Today's date: _______________

BABY'S NAME: ____ DOB: _________

Pasteurized Donor Human Milk for supplementation, ad lib, use as needed

SIG: Dispense: # bottles (4 oz each): *circle one* #5 #10 other #___
(may partial fill as desired by family)

Refills: # of refills __4__or other:_____

Healthcare Provider Signature

Signature: ____

Print Name: ____

Phone number: ________________________

Fax #: __________________________________

Office Name or Hospital: ____

Baby Medical Diagnosis (ICD-10)

☐ Newborn Feeding Problem: *age < 28 days* (P92.9)

☐ Infant Feeding Problem: *age > 28 days* (R63.3)

Provide a copy to the parent to take to a distribution site.
For donor milk pick-up at the Minnesota Milk Bank for Babies,
FAX to: 763-225-4800

2525 Nevada Ave. N., #304
Golden Valley, MN 55427

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763-546-8051 main
www.mnmilkbank.org