# PRESCRIPTION FORM FOR DONOR MILK

The New York **Milk Bank**
Give. Nourish. Thrive.

**Top portion to be completed by parent/caregiver**

Baby First Name ____________________________ Baby Last Name_______________________________

DOB__________ Birth Weight _____________ Gestational age at birth _____________ Gender ________

Parent Name ____________________________________________ DOB _______________________

Phone ____________________________ Email Address ___________________________________

Partner Name ___________________________________________ DOB _______________________

Phone ____________________________ Email Address ___________________________________

Address _____________________________________________________________________________

City _____________________________________ State _________ Zip Code ______________________

## Prescription - to be completed by provider

Date_________________

Baby First Name _______________________ Baby Last Name _________________________ DOB __________

Prescribed volume (per day) _____________________________________

length of time _________________________________

Diagnosis ____________________________________ ICD-10 Code _____________________________

Prescribing Physician (print name) ________________________________________________________

Physician Signature _____________________________________________________________________

NPI # _________________________________ Phone ________________________________________

Clinic/Hospital __________________________________________________________________________

Address _______________________________________________________________________________

City ___________________________________ State ____________ Zip Code _____________________

**Email this form along with the consent form and credit card form**

**IMPORTANT:**
**Orders are not final until families contact the milk bank to confirm availability and finalize order details.**

Phone: 212-956-MILK (6455)
Email: ordermilk@nymilkbank.org
Fax: 914-202-3358

# Consent Form for PDHM for Infants

Human milk is the standard food for infants and young children, including premature and sick newborns, with rare exceptions. Human milk provides optimal nutrition, promotes normal growth and development, and reduces the risk of illness and disease. The unique composition of human milk, which includes nutrients, enzymes, growth factors, hormones, and immunologic and anti-inflammatory properties, has not been duplicated. When mother's own milk is not available or there is not sufficient volume, pasteurized donor human milk (PDHM) from a recognized donor human milk bank is the next best option. PDHM contains most of its bioactive properties, which protect the baby from infection while the nutritional components of the milk are the least difficult for the baby to digest.

The New York Milk Bank, Inc. is a 501(c)3 nonprofit donor human milk bank licensed by the New York State Department of Health (NYSDOH) and a member of the Human Milk Banking Association of North America (HMBANA). We follow the mandatory guidelines from NYSDOH and HMBANA to ensure the safest product possible is provided. All donors provide milk on a voluntary basis. Only healthy women who are substance-free, non-smokers and have a healthy lifestyle are accepted as donors. All potential donors are triple screened, including verbal and written screening, contact with the mother's healthcare provider, and blood screening. The blood screening for donors includes tests for HIV, HTLV, syphilis, and hepatitis and all results are negative or non-reactive. The donor is screened, the milk is pasteurized, and then cultured for bacterial growth after pasteurization and before it is released from the milk bank. Although there is a small risk when accepting donor milk, the risk is minimized due to strict processing procedures. There has been a 0% infection rate since these guidelines were adopted in 1985.

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I understand the above information about pasteurized donor human milk and consent to the use of electronic signatures hereto.

I, ____________________________________________(legal Guardian),
(PRINT NAME)
am in agreement that my baby/child ___________________________________will
(PRINT NAME)
receive pasteurized donor human milk.

___________________________________ ______________
SIGNATURE DATE

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**PAYMENT INFORMATION**

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number:______________________________________________________________

Expiration Date:_________________________________________ CVV:_____________________

Name on Card:___________________________________________________________________

Billing Address:__________________________________________________________________

City:______________________________State:__________________Zip____________________