

**DEMOGRAPHICS**

Please fill this form out completely.

Baby

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Gender: \_\_\_\_ Gestational Age: \_\_\_\_\_ weeks

Diagnosis: \_\_\_\_\_

ICD-10 code: \_\_\_\_\_

Mom/Parent

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Partner/Dad/CoParent

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referred by: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

**How to write a prescription:**

Baby's Name and DOB

Diagnosis (Dx) and ICD-10 codes (**must include**)

PDHM (pasteurized donor human milk)

Prescribed volume (per day or per feed in mL): i.e. 900-1000mL per day or amount per feeding

Duration: for how many days, weeks, months

Refills: number of refills or a period of time

Fax it to us at 914.202.3358 or email it to: [ordermilk@nymilkbank.org](mailto:ordermilk@nymilkbank.org)

401 Columbus Avenue, Valhalla, NY 10595. Questions? Call us! 212.956.MILK (6455)

**The processing fee for donor milk is approximately \$4.00/per ounce. The size bottle that we are able dispense is based upon our availability.**

**\*\*Orders are not final until families contact the milk bank to confirm availability and finalize order\*\***