Date:

BREAST PUMP PRESCRIPTION

Name of Mother*: ______________________________ DOB: ____________

Name of Baby*: ______________________________ DOB: ____________

Address (if known): ____

*Benefits vary by insurer and plan, including by whom and for whom prescriptions must be written. RIte Care benefits are posted on the Department of Health website at www.health.ri.gov/family/breastfeeding/insurancebenefits.php

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MANUAL BREAST PUMP

☐ Manual Breast Pump (for short-term or occasional use)

Specify reason: ____

ELECTRIC BREAST PUMP

Rx (select one type of pump)

☐ Hospital Grade Electric Breast Pump **with** ☐ Double Pump Kit (separate item)
☐ Individual Electric Breast Pump (limited coverage—verify prior to requesting)

Reason (select one)

☐ NICU / Prolonged Hospitalization
☐ Mother unable to use manual pump for medical reasons
☐ Breastfeeding and / or manual pump insufficient as evident by **(circle at least one)**:

inadequate milk production / poor infant weight gain / jaundice /
failure to establish an effective breastfeeding pair / poor latch / damaged nipples

☐ Returning to work or school (extremely limited coverage—verify prior to requesting)
☐ Other Diagnosis: ____

Length of Need

☐ ______ (number of) months **OR** ☐ Indefinite / as long as breastfeeding

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AUTHORIZATION

SIGNATURE: ________________________ MD / DO / NP / CNM / PA

OR include PROVIDER STAMP or LABEL for contact info

Printed name: ________________________

Address: ________________________

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Phone #: ________________________

UPIN#: ________________________

DEA #: ________________________

Developed by the Physicians Committee for Breastfeeding in Rhode Island and the Rhode Island Breastfeeding Coalition in August 2008. Appropriate use encouraged to support breastfeeding and ultimate health outcomes.

Rhode Island Breastfeeding Coalition

Revised 11/1/08