Date: _____

Proxy may provide to WIC clinic for mother/baby certification if form is completed in its entirety with all requested information.

MEDICAL NECESSITY BREAST PUMP REQUEST

This form serves as a letter of medical necessity for a breast pump ensuring patient under your care receives appropriate pump to be used to support breastfeeding and ultimate health outcomes.

Mother's Name: _____ DOB: _____

Pre-Pregnancy weight: _____ Current weight: _____ Ht: _____ Hemoglobin/HCT: ____

Baby's Name: _____ DOB:_____ Gest Age:_____

Birth weight: _____ Length:_____ Imm Status:_____ Formula Supplementation: □ Yes □ No

Address: _____ Phone #: _____

Is Mother currently receiving WIC? □ Yes □ No WIC Family ID#: _____

Mother's Primary Insurer: _____ Medical Pump Coverage? □ Yes □ No

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Breast Pump Types (please choose). Only single-user pumps will be issued to mothers who are actively diagnosed with and /or recently tested positive for Covid-19.

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

□ Hospital Grade Electric Pump with □ Double pump attachment kit

□ Individual Electric Breast Pump (single user)

Reason (check all that apply)

□ Baby in NICU with expected stay greater than 72 hours

□ Difficult latch/poor latch □ Mastitis

□ Inadequate milk production □ Engorgement

□ Poor infant weight gain □ Retracted (inverted) nipples

□ Jaundice □ Cracked nipples

□ Tongue tie □ Poor suck/muscular weakness

□ Milk oversupply □ Plugged milk duct

□ Thrush (fungal infections) □ Cleft palate

□ Multiple live births □ Failure to establish effective breastfeeding pair

□ Mother returning to work or school □ Pre-term infant

□ Other: _____

Length of need (hospital grade electric pump that is loaned only): □ _____ months □ indefinite

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AUTHORIZATION (MD/NP/PA/IBCLC/RN) Signature: _____

Please email this form to BFPCReferrals@la.gov for processing.