Maternal Provider Form – Approval to Donate Milk

UNIVERSITY OF CALIFORNIA HEALTH Milk Bank

Patient Name: _____ DOB:_____

Your patient has volunteered to donate her extra milk to our non-profit milk bank. Her milk will be processed, pasteurized, and distributed to premature infants or outpatients in the region. Your patient authorized you to complete this form and provide information that is relevant to milk donation.

To the best of your knowledge, did/does your patient:

Take prescription medications on a regular basis? ☐ Yes ☐ No

If yes, list medications:_____

Have an increased risk of HIV or other sexually transmitted infections? ☐ Yes ☐ No

Receive a blood transfusion or blood product (other than Rhogam) in the past year? ☐ Yes ☐ No

If yes, transfusion date: _____

Receive any live virus vaccine (MMR, Varicella, Shingles, Oral Polio, Yellow Fever, Smallpox, Typhoid) in the past year? ☐ Yes ☐ No

if yes, name of vaccine _____ date of vaccination _____

Prenatal Lab Results

Lab Test	Date	Negative	Positive	Equivocal	Not Done
Hepatitis C	___/___/___	☐	☐	☐	☐
HBsAg	___/___/___	☐	☐	☐	☐
HIV 1/2/0	___/___/___	☐	☐	☐	☐
Syphilis screen	___/___/___	☐	☐	☐	☐

To the best of my knowledge, the above patient is in good health and would be an appropriate donor to the milk bank.

Licensed Health Care Provider (please print): _____

Signature _____ Date _____

Fax completed form to 858-732-0870 or email to ucmilkbank@health.ucsd.edu