Request for Breast Pump Assistance from the Texas WIC Program

Mom's Name: _____ DOB: _____

Infant's Name: _____ DOB: _____ Birth Weight: _____ Weeks Gestation: _____

Referring Facility: _____ Date: _____

I am referring this patient to the Texas WIC program for assistance with a breast pump. After thorough assessment, it has been determined that this mother is experiencing the following breastfeeding complications in which a breast pump is indicated:

(Check all that apply.)

- ❑ Mother/Infant Separation (including infant in NICU).
- ❑ Infant with special needs. *Explain:* _____
- ❑ Mother of multiple newborns.
- ❑ Other. *Explain:* _____

(Check all that apply.)

- ❑ Patient is currently enrolled in WIC. *Call and request a breast pump from the WIC clinic prior to discharge to expedite pump issuance.*
- ❑ Patient would like to apply for WIC. *WIC pump issuance is limited to individuals who are enrolled in the WIC program. To locate the nearest WIC clinic call 1 (800) 942-3678.*
- ❑ Patient has received an Ameda HygieniKit.
- ❑ Patient has been trained on proper storage of human milk.
- ❑ Patient has used or has been trained on how to assemble, use, and clean the Ameda multiuser breast pump and collection kit.

_____	_____	_____
Signature and Title of Health-Care Provider	Printed Name	Phone Number

I, _____ (patient first and last name), authorize my health-care provider, _____ (health-care provider name), to release information on this form to the WIC program, and I authorize the WIC program to release information about me to this health-care provider for the purpose of coordinating my health care. I understand that all information is considered confidential.

Signature of Participant/Parent/Guardian: _____ Date: _____

Yo, _____ (nombre y apellido del paciente), autorizo a mi proveedor de atención médica, _____ (nombre del proveedor de atención médica), para divulgar información en esta forma al Programa para Mujeres, Bebés y Niños (WIC) y autorizo al programa WIC para divulgar mi información personal a este proveedor de atención médica con el propósito de coordinar mi atención médica. Entiendo que toda esta información se considera confidencial.

Firma de la participante, o de su padre o tutor: _____ Fecha: _____

TEXAS Department of State Health Services

BREASTMILK EVERY OUNCE COUNTS

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