

ITC MEDICAL SUPPLIES

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Patient (Last and First Name):	
Address:	
Telephone:	Date of Birth:
Medi-Cal ID:	Infant Name: DATE OF BIRTH:
BREAST PUMP (ELECTRIC HOSPITAL GRADE) E0604 RR	
BREAST PUMP KIT – E0602 NU- 2/MO	
<p style="text-align: center;"><u>MATERNAL DIAGNOSIS</u></p> <p>() 676.94 Contraindicated drug use (need to sustain milk supply)</p> <p>() 676.94 Mother/baby separation due to hospitalization</p> <p>() 676.94 Establish milk supply</p> <p>() 611.8 Plugged milk duct</p> <p>() 676.44 Failure of lactation</p> <p>() 676.54 Suppressed lactation</p> <p>() 676.24 Engorgement of breasts</p> <p>() 676.14 Nipple cracked/ blister/fissures</p> <p>() 675.14 Breast abscess</p> <p>() 611.71 Breast pain</p> <p>() 676.34 Nipple pain/trauma/ulcer</p> <p>() 676.94 Infection of nipple</p> <p>() 676.0 Nipple-inverted/retracted</p> <p>() 675.10 Mastitis, purulent</p> <p>() 675.20 Mastitis, nonpurulent</p> <p>() Other _____ Include ICD-9 code: _____</p> <p style="text-align: center;"><u>INFANT DIAGNOSIS</u></p> <p>() 779.31 Feeding problems-newborn (nipple preference/tongue thrust/weak suck/ latch-on difficulty/refusal to suck)</p> <p>() 783.3 Feeding problems, Infant (>28 days)</p> <p>() 789.0 Colic</p> <p>() 771.7 Thrush</p> <p>() 774.6 Jaundice, neonatal</p> <p>() 276.5 Dehydration, neonatal</p> <p>() 779.34 Slow wt. gain/FTT (newborn)</p> <p>() 783.41 Slow wt. gain/FTT (older Infant)</p> <p>() 765.20 Prematurity/LBW (NOS)</p> <p>() 750.0 Ankyloglossia</p> <p>() 749.00 Cleft palate (NOS)</p> <p>() 749.10 Cleft lip (NOS)</p> <p>() 749.20 Cleft lip & palate (NOS)</p> <p>() 744.9 Cranial facial abnormality that prevents latch-on & adequate milk intake</p> <p>() 780.54 Sleepy baby</p> <p>() Other _____ Include ICD-9 code: _____</p>	
PROGNOSIS	
DURATION OF NEED _____ Months _____ Years _____ Lifetime _____	
PHYSICIAN'S SIGNATURE	DATE:
I certify that the information provided is a true and accurate representation of my patient's current co edition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.	
PHYSICIAN (First and Last Name):	
ADDRESS:	TELEPHONE:
NPI:	LICENSE Number: