**ITC MEDICAL SUPPLIES**

***4373 GEARY BLVD***

***SAN FRANCISCO, CA 94118***

***TEL: 415/387-7100 FAX: 415/387-2540***

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| --- | --- | --- | --- |
| **Patient (Last and First Name):** | | | |
| **Address:** | | | |
| **Telephone:** | **Date of Birth:** | | |
| **Insurance ID:** | **Infant Name:**  **Date Of Birth**: | | |
| **BREAST PUMP (ELECTRIC HOSPITAL GRADE) E0604 RR**  **BREAST PUMP KIT – E0602 NU- 2/MO**  d | | | |
| MATERNAL DIAGNOSIS **( ) O92.70** Contraindicated drug use (need to sustain milk supply)  ( ) **O92.70** Mother/baby separation due to hospitalization  **( ) O92.70** Establish milk supply  **( ) N64.9** Plugged milk duct  ( ) **O92.3** Failure of lactation  ( ) **O92.5** Suppressed lactation  ( ) **O92.29** Engorgement of breasts  ( ) **O92.13** Nipple cracked/ blister/fissures  ( ) **O91.12** Breast abscess  ( ) **N64.4** Breast pain  ( ) **O92.20** Nipple pain/trauma/ulcer  ( ) **O91.02** Infection of nipple  ( ) **O92.02** Nipple-inverted/retracted  ( ) **O91.119** Mastitis, purulent  ( ) **O91.219** Mastitis, nonpurulent  ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Include ICD-10 code**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INFANT DIAGNOSIS ( ) **P92.9** Feeding problems-newborn (nipple preference/tongue thrust/weak suck/ latch-on difficulty/refusal to suck)  ( ) **R63.3** Feeding problems, Infant (>28 days)  ( ) **R10.83** Colic  ( ) **P37.5** Thrush  ( ) **P59.9** Jaundice, neonatal  ( ) **E86.0** Dehydration, neonatal  ( ) **P92.6** Slow wt. gain/FTT (newborn)  ( ) **R62.51** Slow wt. gain/FTT (older Infant)  ( ) **P07.30** Prematurity/LBW (NOS)  ( ) **Q38.1** Ankyloglossia  ( ) **Q35.9** Cleft palate (NOS)  ( ) **Q36.9** Cleft lip (NOS)  ( ) **Q37.9** Cleft lip & palate (NOS)  ( ) **Q18.9** Cranial facial abnormality that prevents latch-on & adequate milk intake  ( ) **G47.10** Sleepy baby  ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I**nclude ICD-10 code**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | ()CHF O MI  OPEN HEART SURGERY  EPEMA  DIZZINESS S |
| **PROGNOSIS** | | |
| **DURATION OF NEED Months** | | | |
| **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'smedical record. This document is supported by additional medical records in my patient's file. | | | |
| **PHYSICIAN (First and Last Name):** | | | |
| **ADDRESS:** | | **TELEPHONE:** | |
| **NPI:** | | **LICENSE Number:** | |
| **Name of Person sending form:** | | **Date:** | |