**Prescription Card for infant milk formula[[1]](#footnote-1)**

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

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| POC INFORMATION |
| Child Name: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_   First Name Last NameSex: ☐ Male ☐ Female | Mother Name: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Name Last NameAddress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Tel. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   DD MM YYYY  Programme #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| REFERRAL CRITERIA |
| ☐ Social – No need for breast examination: For permanent infant condition no breast examination is needed (Only prescription).  |  ☐ Medical – Breast examination (For temporary infant conditions and mother conditions). |
| PRESCRIPTION CRITERIA |
| NON-MEDICAL – NO breast EXAMINATION | MEDICAL – *(To Be Filled by Health Provider, Midwife or Pediatrician )* |
| ☐ Child is orphaned - wet-nursing is not possible.☐ Child is temporarily or permanently separated from mother.☐ Mother has stopped breastfeeding and re-lactation is: ☐ ongoing or ☐ failed.☐ Infant rejected by mother☐ Infant refuse breast milk  | **Infant conditions (permanent – special formula needed):**☐ Galactosemia ☐ Maple syrup urine disease ☐ Phenylketonuria☐a syndrome or an inborn error in metabolism**Infant conditions (Temporary):**☐ low birth weight (1.5 < gm)☐ pre-term infant (< 32 weeks of gestational age)☐ Newborn at risk of hypoglycemia**Mother conditions - with Breast Feeding (Temporary):**☐ Breast abscess ☐ Hepatitis B ☐ Hepatitis C☐ Mastitis ☐ TB ☐ Substance use ☐Engorged breast, flat/inverted nipples**Mother conditions- No Breast Feeding (Temporary):**☐ Severe illness☐ Medication contra indication[[2]](#footnote-2)☐ Herpes simplex virus type 1 (HSV-1) |
| Prescription (to Pharmacy) |
| Date of Prescription: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ DD MM YYYY Child Name : \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Sex: ☐ Male UNHCR #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   First Name Last Name DD MM YYYY  ☐ Female Qty in Ml/ Day: \_\_\_\_\_ Number of Days: \_\_\_\_\_ Total Qty (tin): \_\_\_\_\_\_\_  Date of follow up: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  DD MM YYYYIYCF counselor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(pediatrician/midwife) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SC Manager or LGA Nutrition Manager Approval** |
|  Official StampDate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Organisation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Adapted from IMC Jordan [↑](#footnote-ref-1)
2. Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids; Radioactive iodine-131 is better avoided given that safer alternatives are available; excessive use of topical iodine or iodophors [↑](#footnote-ref-2)