**BMS Prescription Referral Form[[1]](#footnote-1)**

*Part One: To be completed at referring site and sent to the referral agency (SC in charge) as well as kept in referring agency records for follow-up*

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| **Referral Information** Referral Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Referral Follow-up Completed: Yes / No |
| Referring Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Job Title/Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Information/Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Referral to Service/ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information/ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When to Attend: Immediately/ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral Transportation Plan: Self/ Referring Agency Supported Transport.  |
| **Person of Concern Details** |
| Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ☐ Male ☐ FemaleChild Age in Months:\_\_\_\_\_\_\_\_ | Mother/Caregiver Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Details/Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Mother/Caregiver location/address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| IYCFE/OTP/SC or Health Facility Identification Number#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the Full Assessment form Included with this referral form? Yes / No*Always ensure that the Full Assessment is sent along with this form to the SC in charge and follow-up in completed between the referring and receiving agencies and that a transportation is in place for the referral.* |
| **REFERRAL CRITERIA** |
| * **Temporary BMS indication:**
* During relactation
* Transition from mixed feeding to exclusive breastfeeding
* Short-term separation of infant and mother
* Short-term waiting period until wet nurse or donor human milk is available
 | * **Longer-term BMS indication:**
* Infant not breastfed pre-crisis
* Mother not wishing or unable to relactate
* Infant established on replacement feeding in the context of HIV
* Orphaned infant
* Infant whose mother is absent long-term
* Specific infant or maternal medical conditions[[2]](#footnote-2)
* Very ill mother
* Infant rejected by mother
* A survivor of Gender Based Violence not wishing to breastfeed.
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|  |

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*Part Two: To be completed at referring site and given to caretaker (as record of next steps and to show the referral facility)*

**Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Agency Contact Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Referral Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to Attend: Immediately/ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Transportation Plan: Self / Referring Agency Supported Transport.

**Reason for Referral:**

* **Temporary BMS indication:**
* During relactation
* Transition from mixed feeding to exclusive breastfeeding
* Short-term separation of infant and mother
* Short-term waiting period until wet nurse or donor human milk is available
* **Longer-term BMS indication:**
* Infant not breastfed pre-crisis
* Mother not wishing or unable to relactate
* Infant established on replacement feeding in the context of HIV
* Orphaned infant
* Infant whose mother is absent long-term
* Specific infant or maternal medical conditions[[3]](#footnote-3)
* Very ill mother
* Infant rejected by mother
* A survivor of Gender Based Violence not wishing to breastfeed.

**Recommendations for Follow-up:**

1. Developed by GNC Technical Alliance Technical Support Team Advisor for the NE Nigeria Nutrition Sector [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)