**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*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 ☐ Female  Child 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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*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)