



9449 S. KEDZIE, SUITE 380
EVERGREEN PARK, ILLINOIS 60805
PHONE / FAX 888 404 7467 (PHMS)

PROVIDER ORDER FORM (RX) - MATERNITY HOME MEDICAL SUPPLIES

Patient Name / Nombre: _____

Phone Number / Numero De Telefono: _____

Street Address / Domicilio: _____

Home

Apt: _____ City/Ciudad: _____ State/Estado: _____ Zip/Codigo Postal: _____ Clinic

Date Of Birth / Fecha De Nacimiento: _____

Height/Altura: _____ Weight/Peso: _____

EDC / Due Date/Fecha Del Parto: _____ English / Spanish

Payment Method: Medicaid (Attach Copy of IDHFS Card) **Presumptive Eligible and HMO NOT ACCEPTED**

ELECTRIC BREAST PUMP

Electric Breast Pump (Medela 67272)

DIAGNOSIS

- Lactation
- Engorgement of Breasts
- Mastitis
- Infection of nipple
- Retracted / Inverted Nipple
- Unspecified Disorder of Lactation
- Breastmilk Jaundice
- Cleft Lip / Palate
- Down's Syndrome
- Infant Feeding Difficulty
- Suck Reflex Abnormal
- Failure to Thrive

PLEASE CHECK IF REFERRAL FROM WIC DEPARTMENT

LOCATION: _____

Provider Signature: _____ Date: _____

Provider Name (Print) _____ Phone: _____

Address: _____

City: _____ State: **Illinois** Zip: _____ Email: _____

PLEASE FAX RX AND IDHFS INFORMATION TO 888 404 7467 (PHMS)

DOWNLOAD FORMS @ WWW.PERINATALHOMEMED.COM

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