



REFERRAL FORM

Phone: 1-855-414-MILK(6455) Fax: 1-855-543-8942

Client Information:			
*Mother's Name:		Mother's DOB:	
Mother's Due Date or Baby's Date of Birth:		Address:	
City/State:			Zip:
*Phone:		Email:	
Insurance Information:			
Primary:			
ID#:			
Physician information:			
Name:		Phone:	

- You may submit a referral with only the mother's name and phone number.

Vital Milk provides insurance-covered breast pumps and mother-to-mother evidence based lactation support to mothers throughout Massachusetts. If a mother needs a higher level of care beyond the scope of our services, Vital Milk works to connect her to a specialist before leaving her home. Vital Milk continues to follow-up with the mother until a new provider is established, ensuring the continuity of care for both the mother and her infant.

Please check one of these boxes if you would like Vital Milk to:

- Notify you upon receipt of this form
- Notify you upon scheduled delivery date
- Notify you once the delivery has been made

Name: _____

How would like us to contact you? Phone/Email/Fax: _____

FAX CONFIDENTIALITY NOTICE: This fax, including any attachments may contain material protected and governed by the Health Insurance and Portability and Accountability Act (HIPAA). This fax and any files transmitted with it are confidential and are intended solely for the use of the individual or entity to which they are addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless authorized. If you are not the intended recipient of this fax please note that you have received this fax in error and any use, dissemination, forwarding, printing or copying of this fax is strictly prohibited. If you have received this fax in error, please immediately contact the sender of this message.

If you would like brochures, posters or business cards for your facility please send a request to:

dawn@vitalmilk.com

This form is downloadable from our website: VITALMILK.COM