



Name of Hospital:

Ward:

## Consent for the use of Donor Human Milk (DHM) from the Hearts Milk Bank

If you wish your baby to receive donor human milk from the Hearts Milk Bank please complete the following and return it to the doctor or nurse looking after your baby. It will be kept in your baby's notes.

Baby's name:

Baby's date of birth:

Baby's hospital number:

	Yes	No
I have read the information sheet about donor human milk from the Hearts Milk Bank:	<input type="checkbox"/>	<input type="checkbox"/>
I have had the opportunity to ask questions about feeding my baby with DHM:	<input type="checkbox"/>	<input type="checkbox"/>
I consent to my baby (named above) receiving DHM if I am unable to provide enough of my own breastmilk:	<input type="checkbox"/>	<input type="checkbox"/>

Caregiver's forename:

Caregiver's surname:

Address

  

Signature:

Date: