

**INFORMED CONSENT FOR THE USE OF PASTEURIZED HUMAN DONOR MILK**

My Doctor/Nurse Practitioner \_\_\_\_\_ has explained to me why my baby \_\_\_\_\_ is eligible to receive Pasteurized Human Donor Milk. I have been given information explaining the use of Pasteurized Human Donor Milk and have been given the opportunity to ask questions or request further information. I am satisfied with the explanation given to me at this time and am aware that I may ask for further clarification.

- I understand the risks of using Pasteurized Human Donor Milk
- I understand the benefits of using Pasteurized Human Donor Milk
- I understand that Pasteurized Human Donor Milk will be discontinued when my own breastmilk is available in adequate amount, or my infant is considered to be stable enough to be fed formula
- I understand that the use of Pasteurized Human Donor Milk is based on availability and that if there is no Pasteurized Human Donor Milk available, my baby will be fed the most appropriate alternative
- I understand that I may choose to withdraw consent at any time and for any reason and it will not affect the quality of care that my baby receives

By signing this document, I give my permission for my baby to receive Pasteurized Human Donor Milk.

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date (yy/mm/dd)

\_\_\_\_\_  
Name of Physician/Nurse Practitioner

\_\_\_\_\_  
Signature of Physician/Nurse Practitioner

**INTERPRETER DECLARATION**

I believe I have accurately interpreted the conversation between \_\_\_\_\_ and \_\_\_\_\_ and I believe the person understood the information given.

\_\_\_\_\_  
Name of Interpreter

\_\_\_\_\_  
Signature of Interpreter

\_\_\_\_\_  
Mode of Communication

\_\_\_\_\_  
Date (yy/mm/dd)