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| **Rotary Community**  **Breast Milk Bank** | SURNAME……………………………………………………..NHI…………………………….  FIRST NAME……………………………………………………DOB…………………………..  ADDRESS……………………………………………………………………………………………  BABY’S NHI ……………………………….. ETHNICITY……………………………………  CONTACT PHONE: …………………………………………………………………………..  EMAIL: ……………………………………………………………………………………………... |

**Consent by recipient parent/guardian for use of donor breast milk:**

Breast Milk is the ideal milk for babies. The Rotary Community Breast Milk Bank aims to provide some donor breast milk to babies and mothers who meet our recipient criteria, generally up until the baby is six weeks old. We hope this short-term gift of donor milk will support the continuation of breastfeeding. *Tick*

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| I have read the information about the Rotary Community Breast Milk Bank |  |
| The importance of pasteurised breastmilk has been explained to me |  |
| The potential risks of pasteurised donor breastmilk have been explained to me |  |
| I am aware that the donor mother has been carefully screened for infectious diseases such as Hepatitis B antigen; Hepatitis C; HTLV-1 & 2; Rubella; Syphilis and has been asked questions about her general health and lifestyle |  |
| I have been given information on the collection, storing, freezing, pasteurisation, and bacterial testing processes that donor milk undergoes. |  |
| I am aware that all information relating to the donor mother will be kept confidential except her unique ID number. I am also aware that I will not receive any personal information relating to the donor mother and her family, including their identities. |  |
| I am aware that all Information collected in relation to my baby’s use of donor milk could be shared between the Rotary Milk Bank, other providers and will be placed on my baby’s clinical record. |  |
| In the event that I do not use all the PDM issued to me, and providing the PDM has not been thawed, I agree to return it to the Rotary Milk Bank as soon as possible. |  |
| I agree that I will not, under any circumstances, pass PDM issued to me to another person to be given to any other baby. |  |
| I agree to dispose of any unused PDM that has been thawed. |  |

This donor breast milk has been obtained, stored, transported, processed, and pasteurised under conditions that facilitate high standards of health and safety. Breast milk can carry viruses and bacteria but donor screening, safe transport, storage of milk, freezing, sample testing, and pasteurisation should eliminate risk.

I am satisfied with the information and education I have been given and all my questions have been answered to my satisfaction by the person witnessing this form.

I am aware donors sign confirming that they have not had any medications other than occasional Paracetamol or Thyroxine.

A cooler bag and frozen ice pad are required to transport the milk to your home. These are available at the milk bank if needed. A $10 refundable bond is required, this can be paid in cash or by internet banking

The PDM is supplied to you in reusable bottles and we would appreciate if you would return them to us. When you take a bottle out of your freezer can you please remove the sticky label as this is much easier to do before the milk thaws, then clean the bottles in hot soapy water, using a bottle brush inside them and on the lid ridges , before rinsing thoroughly and turning upside-down to air dry on a clean tea towel (or paper towels). By doing this and returning the bottles to us it is helping the RMB keep their expenses down, and helping to keep the environment cleaner. Thank you.

By signing this form, the recipient adult recognizes that all risks cannot always be entirely eliminated and the use of donor breast milk supplied by the Rotary Community Breast Milk Bank remains the ultimate responsibility of the parent, guardian, or care giver.

Name of recipient baby:…………………………………………………………………………………………………………………………….

Name of parent/guardian:………………………………………………………………………………............................................

Signature of parent/guardian:……………………………………………………………………………..…Date:…………………………

Name of witness: RMB Volunteer:…………………………………………………………………………………………………………….

Signature of witness:…………………………………………………………………………………………..…Date:…………………………

Audit Permission:

We request your permission to call you to collect information from you to be used anonymously to audit our performance

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| Has your baby been exclusively breastfed? | YES/NO |
| Has our assistance been enough to enable you to exclusively breastfeed? | YES/NO |
| Were we able to supply the pasteurised donor milk? | YES/NO |
| Or, had we run out of PDM? | YES/NO |
| How long has your baby been exclusively breastfed? |  |

I give permission for a volunteer from the RMB to contact me to discuss the above questions

Name of parent/guardian:………………………………………………………………………………............................................

Signature of parent/guardian:……………………………………………………………………………..…Date:…………………………

**Rotary Breast Milk Bank, 1st Floor St Georges Hospital, Heaton Street, Christchurch. Phone: 03 3756281**