Te Whatu Ora
Health New Zealand
Waitaha Canterbury

Human Milk for Our Babies

(Place patient label here or complete details)

NAME:

GENDER: DOB: AGE: NHI:

ADDRESS:

Mother Wishing to Donate Human Milk: Consent

As a mother exclusively breastfeeding/breastmilk feeding her baby I consent to donate my surplus milk to the Human Milk Bank.	☐ Yes	☐ No
I have read the information leaflet about donating milk to the Human Milk Bank	☐ Yes	☐ No
I have understood the process for collecting, storing and the transportation of my milk to the Human Milk Bank.	☐ Yes	☐ No
I have read and signed the health and lifestyle questionnaire.	☐ Yes	☐ No
To the best of my knowledge, there is no reason why I should not donate my milk.	☐ Yes	☐ No
I understand that once donated, the donated milk cannot be returned to me.	☐ Yes	☐ No
I consent to my breast milk being used for research and training purposes.	☐ Yes	☐ No
I understand I will need to be screened for the following blood infections prior to donating my breast milk: Human Immunodeficiency Virus 1 & 2 (HIV) Hepatitis B & C Human T Cell Lymphotropic Virus 1 & 2 (HTLV) Syphilis (SEIA)	☐ Yes	☐ No
I understand that the results of my blood tests will be communicated to me by milk bank staff. Blood results can be accessed by GP.	☐ Yes	☐ No
I consent to the information collected in relation to my milk donation being shared with CDHB staff as appropriate.	☐ Yes	☐ No
I understand that I will not receive any personal information relating to the recipients of my milk, including their identities.	☐ Yes	☐ No

Mother's name

Mother's signature _____ Date

STAFF USE ONLY

Statement of health care professional with an appropriate knowledge of the human milk bank policies.

I have discussed the process with the mother and explained the following:

- The benefits of human milk for the sick and preterm baby
- Information about donating human milk
- How to collect and store the milk
- Reasons for temporarily stopping donation
- The screening process

Name of Health Care Professional

Job Title

Signature of Health Care Professional _____ Date

DONOR MILK CONSENT

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