



Tidewater Lactation Group, Inc
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Tricare Breast Supplies Order Form

Patient Information: All Fields required

Name (Mother): _____ Mothers Date of Birth: _____
Street: _____ City/State/Zip: _____
Phone: _____ Baby Date of Birth or Due Date: _____
Sponsors Name: _____ Sponsors **FULL** SSN: _____
Relationship to Sponsor: _____ Email Address: _____

Select Your Pump:



Spectra S2

<u>Item Needed</u>	<u>Total Needed</u>
24.0mm breast Flanges (1)	_____
28.0mm breast Flanges (1)	_____
32.0mm breast Flanges (1)	_____
Massager insert flange (1)	_____
Backflow Protector (1)	_____
Spectra Storage bags (box of 30 ct)	_____
Duckbill White Valve (1)	_____
Replacement Blue Valves (1)	_____
Skinny Neck Adapters (2)	_____