RAPID ACCESS
VANCOUVER BREASTFEEDING CENTRE REFERRAL FORM

Department of Family Practice
University of British Columbia
Suite 340-943 West Broadway
Vancouver B.C V5Z 4E1

FAX: 604-738 -1231
TEL: 604-738-1912
www.breastfeedingclinic.com

****PLEASE COMPLETE ALL BOLDED SECTIONS (AT MINIMUM)****

- **DOCTOR PREFERRED:** __ First Available
  __ Dr. V. Livingstone #3549
  __ Dr. B. Lin #25453
  ___ Dr. Rowthorn #63797
  ___ Dr. L.J. Stringer #9121
  ___ Dr. K. Jansen #28089

- **REFERRING DR / RM:** ______________ **MSP BILLING #:** ______________.

  FAX #: ______________

- **MOTHER'S NAME**: ______________ **D.O.B.** / / **PHN #:** ______________
  DD / MM / YY
- **PHONE #:** ______________ ADDRESS: ______________
- **INFANT'S NAME**: ______________ **D.O.B** / / **PHN #**: ______________

  INFANT'S NAME (TWIN B): ______________ D.O.B / / PHN#: ______________

REASON FOR REFERRAL:

□ EMERGENCY WITHIN 24 HOURS □ URGENT WITHIN 2-3 DAYS □ ROUTINE WITHIN 1 WEEK

PLEASE NOTE:
- We will contact patient directly to book appointment and return referral with confirmed appointment time.
- Please ask patient to bring a hungry baby to appointment (do not feed for at least 2 hours before appointment).
- For further information suggest patient visit our website: www.breastfeedingclinic.com.
- **Please submit a GP referral - ICD code 676 for mother and ICD code 783 for infant – upon receiving appointment confirmation**

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FOR CLINIC USE ONLY:

APPOINTMENT DATE & TIME: ______________

DOCTOR TO BE SEEN:

□ Dr. V. Livingstone #3549 □ Dr. Stringer #9121 □ Dr. B. Lin #25453 □ Dr. Jansen #28089

□ Dr. Rowthorn #63797

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  FAX #:
  PH #:

- **MOTHER'S NAME:** **DOB:** DD/MM/YY **PHN#:**
- **PHONE #:**
- **INFANT'S NAME:** **DOB:** DD/MM/YY PHN #:
- INFANT'S NAME (TWIN B): DOB: DD/MM/YY PHN #:

- REASON FOR REFERRAL:
  EMERGENCY (WITHIN 24 HOURS) URGENT (WITHIN 2-3 DAYS) ROUTINE (WITHIN A WEEK OR MORE)

PLEASE NOTE:
- We will contact patient to book appointment and then fax back referral with confirmed appointment time.
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