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. E. Huettmeyer #67205
___ Dr. J. Wickens #23198
___ Dr. K. Jansen #28089

REFERRING DR / RM: **MSP BILLING #:**

.

FAX #:

***MOTHER'S EMAIL ADDRESS*:**

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**

****

FOR CLINIC USE ONLY:

APPOINTMENT DATE & TIME:

DOCTOR TO BE SEEN:

□ Dr. Livingstone #3549 □ Dr. Huettmeyer #67205 □ Dr. Lin #25453 □ Dr. Jansen #28089 □ Dr. Wickens #23198

PLEASE KEEP A COPY OF THIS FORM FOR FUTURE REFERRALS