RAPID ACCESS
Vancouver Breastfeeding Centre Referral Form

University of British Columbia Department of Family Practice

909-750 West Broadway, Vancouver, BC, V5Z 1H8

FAX: 604-738 -1231 | **TEL: 604-738-1912**

www.breastfeedingclinic.com

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

DOCTOR PREFERRED :

☐ First Available

☐ Dr. Livingstone #3549 (Vancouver) ☐ Dr. Huettmeyer #67205 (Prince George) ☐ Dr. Lin #25453 (Vancouver) ☐ Dr. Jansen #28089 (Vancouver) ☐ Dr. Wickens #23198 (Victoria)

REFERRING DR/RM: ____________________

FAX NO:____________________ **MSP BILLING #:**____________________

MOTHER'S NAME : ____________________

EMAIL ADDRESS: ____________________

DATE OF BIRTH:____________________ **PHN #:**____________________

PHONE NO:____________________

ADDRESS**:** ____________________

INFANT'S NAME:____________________

DATE OF BIRTH:____________________**PHN #:** ____________________

INFANT'S NAME (TWIN B): ____________________

DATE OF BIRTH:____________________ **PHN #:**____________________

REASON FOR REFERRAL:

MUST COMPLETE: ____________________

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☐ 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**

PLEASE KEEP A COPY OF THIS FORM FOR FUTURE REFERRALS

FOR CLINIC USE ONLY:

APPOINTMENT DATE & TIME :____________________

DOCTOR TO BE SEEN : ____________________