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)

DC	DCTOR 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 #:				
	<u>.</u>	FAX #:				
MOTHER'S EMAIL ADDRESS:						
	MOTHER'S NAME:	D.O.B. / / PHN #:				
_		DD / MM / YY				
Ш	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 W	VITHIN 2-3 DAYS				
 PLEASE NOTE: We will contact patient directly to book appointment and return referral with confirmed appointment time. Please ask patient to bring a <u>hungry baby</u> to appointment (do not feed for at least 2 hours before appointment). For further information suggest patient visit our website: <u>www.breastfeedingclinic.com</u>. 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						

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<u> </u>	DOCTOR PREFERRED:	First Available	bleDr. E. Huettmeyer #67205 gstone #3549Dr. J. Wickens #23198				
		Dr. V. Livingstone #3					
		Dr. B. Lin #25453	Dr. K. Janser				
	REFERRING DR/RM:		MSP BILLING	MSP BILLING #:			
			FAX #:				
			PH #:				
0	MOTHER'S NAME:		DOB:	PHN#:			
	PHONE #:		DD/MN	DD/MM/YY			
	INFANT'S NAME:		DOB:	PHN #:			
		DD/MM/YY					
	INFANT'S NAME (TW	IN B):	DOB:	PHN #:			
MOTHER'S EMAIL ADDRESS:			DD/MN	DD/MM/YY			
	REASON FOR REFERR	AL:					
	EMERGENCY (WITHIN 24 HOURS) URGENT (WI		Within 2-3 days)	ROUTINE (WITHIN A WEEK OR MORE)			
PL	EASE NOTE:						
	We will contact patient to book appointment and then fax back referral with confirmed appointment time.						
	Please ask patient to bring a hungry baby; do not feed baby for at least 2 hours before appointment.						
	For further information suggest patient visit our website: www.breastfeedingclinic.com .						
	appointment confirmation						
FC	OR CLINIC USE ONLY:						
	PPOINTMENT DATE &	TIME:					
		····· <u>·</u>					
	OCTOR TO BE SEEN:						
	Dr. V. Livingstone #3549	□ Dr. Wickens #9121 □ □	Dr. B. Lin #25453 □ Dr.	Jansen #28089 □ Dr. Huettmeyer #67205			

PLEASE KEEP A COPY OF THIS FORM FOR FUTURE REFERRALS