306-2502 St. Johns Street
Port Moody, BC
V3H 2B4
Phone: 778-355-9634
Fax: 778-355-9646
E-mail: info@infantfeeding.ca

Tri-Cities Infant Feeding Clinic Referral

Patient name:____________________ PHN: ____________________ Date of birth:____________________ Phone: ____________________	Date of referral:____________________ Referred by: ____________________ ▢ FP ▢ Peds ▢ OB ▢ RN ▢ NP ▢ RM MSP# (if applicable): ____________________
Patient address: ____ E-mail address (if known): ______________________________	
Baby's name: ____________________ PHN (if known): ____________________ Date of birth: ____________________	Mode of delivery: ____________________ Gestational age at delivery:________________ Birth weight: ____________________

Reason for Referral:

Clients will be contacted directly with an appointment as soon as possible. If available, please fax to 778-355-9646:

* Antenatal & delivery records
* Pediatric or other relevant consults
* Relevant lab results (e.g. newborn screen)

Thank you for your kind referral!