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 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: _____	Date of referral: _____
PHN: _____	Referred by: _____
Date of birth: _____	<input type="checkbox"/> FP <input type="checkbox"/> Peds <input type="checkbox"/> OB <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> RM
Phone: _____	MSP# (if applicable): _____

Important: we need *both* maternal and newborn PHNs, etc. to process a referral. Thank you!

Patient address: _____

E-mail address (if known): _____

Baby's name: _____	Mode of delivery: _____
PHN (if known): _____	Gestational age @delivery: _____
Date of birth: _____	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!