B318 - 2099 Lougheed Hwy
Port Coquitlam, BC
V3B 1A8
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:_____	▢ FP ▢ Peds ▢ OB ▢ RN ▢ NP ▢ 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!