|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Rotary Community**  **Breast Milk Bank** | | | **RECIPIENT IDENTIFICATION LOG** | | |
|  | |  | | |  | | |
| **ID No:** | **Mothers Name, NHI, Date of birth :** | | | **Address:** | | | **Phone:** |
|  |  | | |  | | |  |
| **Email:** | | | **Baby’s name: date of birth, NHI; sex and ethnicity:** | | | | **Date:** |
|  | | |  | | | |  |
| **Reason for requiring milk:** | | | **Anticipated level of use:** | | | **Anticipated length of time:** | |
|  | | |  | | |  | |

**LMC Name**:……………………………………………………………………………… A cooler bag and frozen ice pad are required to transport the milk to your home. These are available at the milk bank if needed. A $10 refundable bond is required, this can be paid in cash or internet banking.

**St George’s Staff/ CWH Staff/LMC/ or RMB Volunteer Name:……………………………………………………. Signature: ……………………………………………**

**Rotary Community Milk Bank, 1st floor, St Georges Hospital, Heaton Street, Christchurch. Phone: 03-3756 281**