|  |  |  |
| --- | --- | --- |
|  | **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**