Rotary Community Breast Milk Bank

1st Floor St Georges Hospital,
Heaton Street
Phone 03 3756 281

RECIPIENT REFERRAL FORM

RCBMB ID No:	Mother Details	Address:	Phone:
	Name: **NHI:** **DOB:**		

Email:	Baby Details	Today's Date:
	Name: **Sex:** **DOB:** **NHI:** **Ethnic Group**	

Babies birth weight, gestation, amount being expressed & factors influencing lactation / breastfeeding	Total volume of supplementary PDM required per feed by baby	Amount of PDM required from Milk Bank for 24hrs

- LMC Name……..Phone……..
- Please provide a cooler bag and ice pack for transporting the milk to home/hospital. The Milk Bank can supply these if required for a $20 bond refundable on return (cash or internet banking)
- Please contact the Milk Bank by phone to discuss referral and to ensure that we have PDM available for dispensing.
- Please email this referral form to rotaryc9@gmail.com
- Name of person completing this form……Signature…….

Record of Dispensing PDM to Recipient

Date	Batch Number	Volume Dispensed	Comments	Volunteer Signature	Running Total