



**Rotary Community  
Breast Milk Bank**

1<sup>st</sup> Floor St Georges Hospital,  
Heaton Street  
Phone 03 3756 281

**RECIPIENT REFERRAL FORM**

<b>RCBMB ID No:</b>	<b>Mother Details</b>	<b>Address:</b>	<b>Phone:</b>
	<b>Name:</b>  <b>NHI:</b>  <b>DOB:</b>		
<b>Email:</b>		<b>Baby Details</b>	<b>Today's Date:</b>
		<b>Name:</b> <b>DOB:</b> <b>NHI:</b> <b>Sex:</b>	
<b>Factors influencing lactation / breastfeeding &amp; amount being expressed 3hrly</b>		<b>Babys Details</b>	<b>Amount of PDM required from Milk Bank for next 24hrs</b>
		<b>Ethnic Group:</b> <b>Gestation:</b> <b>Weight:</b> <b>GAP:</b>	

- LMC Name.....Phone.....Name of referrer:.....
- Please **Email this referral** form to [rotaryc9@gmail.com](mailto:rotaryc9@gmail.com), then **Phone** milk bank on 03-3756281 to discuss referral and ensure we have PDM available for dispensing.
- 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)

**Record of Dispensing PDM to Recipient**

<b>Date</b>	<b>Batch Number</b>	<b>Volume Dispensed</b>	<b>Comments</b>	<b>Volunteer Signature</b>	<b>Running Total</b>