YUKON BABY BASKET PROJECT

REFERRAL

Patient/Client information	
First name	Last name
Preferred phone number	Preferred language ☐ English ☐ French
Estimated expected due date YYYY/MM/DD	Expecting multiples ☐ Yes ☐ No

Confirmation of consent and eligibility

By signing this referral, I confirm:

1. I've obtained consent from my patient/client to submit this referral on their behalf to the Baby Basket Project for the purpose of receiving a baby basket.
2. I have informed my client that the program will contact them directly regarding the delivery or pick-up of their baby basket.
3. My client meets the following eligibility criteria:
   - Is a Yukon resident.
   - Is in their third trimester of pregnancy (>28 wks. gestation) or families with a new baby up to 2 months old.

Referral source information		
Location	Name	
Signature		Date (YYYY/MM/DD)

Fax completed forms to: 867-393-7112

More information, call: 867-471-0036

YUKON MIDWIFERY
SUPPORTING YOUR JOURNEY

SOLSTICE maternity

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