

# Request Form for Health Education Resources for Health Professionals

Attn: Nursing Officer  
Family Health Service, Department of Health  
Fax no.: 2574 8977  
Email: [breastfeeding.fhs@dh.gov.hk](mailto:breastfeeding.fhs@dh.gov.hk)

~~~~~  
Date: \_\_\_\_\_

☐ **Obtain health education resources**

|    | Items                                                             | No. of copies requested |
|----|-------------------------------------------------------------------|-------------------------|
| 1. | Self Learning Kit on Breastfeeding for Health Professionals (DVD) |                         |
| 2. | Flip Chart: 「母乳餵哺健康第一步」 (for local professionals only)            |                         |

- ☐ **Receive email information:** Other child health resources from Family Health Service
- ☐ **Register to use the online version:** Self Learning Kit on Breastfeeding for Health Professionals  
(\*Log in user name and password will be sent to your email)

**Contact information**

Name: Prof / Dr / Mr / Ms \* \_\_\_\_\_ (please delete as appropriate)

Phone no.: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Type of Professional:**

|                                 |                                |                                  |
|---------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Nurse | <input type="checkbox"/> Others: |
|---------------------------------|--------------------------------|----------------------------------|

**Specialty:**

|                                    |                                     |                                  |                                  |
|------------------------------------|-------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Obstetric | <input type="checkbox"/> Paediatric | <input type="checkbox"/> General | <input type="checkbox"/> Others: |
|------------------------------------|-------------------------------------|----------------------------------|----------------------------------|

**Professional Organisation (e.g. Academy / College):**

|                       |
|-----------------------|
| _____ (If applicable) |
|-----------------------|

**Practising Organisation:**

|                                      |                                           |                                           |                              |                                     |
|--------------------------------------|-------------------------------------------|-------------------------------------------|------------------------------|-------------------------------------|
| <input type="checkbox"/> HA Hospital | <input type="checkbox"/> Private Hospital | <input type="checkbox"/> Private Practice | <input type="checkbox"/> NGO | <input type="checkbox"/> DH Service |
|--------------------------------------|-------------------------------------------|-------------------------------------------|------------------------------|-------------------------------------|

**Place of Practice:** \_\_\_\_\_

~ For delivery of DVD / Flip Chart (Please fill in your name and postal address) ~

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|                                                                     |                                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------|
| Name: _____                                                         | Name: _____                                                         |
| Address: _____<br>_____<br>_____<br>(please write in block letters) | Address: _____<br>_____<br>_____<br>(please write in block letters) |