Physician Group **REFERRAL FORM**

OntarioBreastfeedingClinic.ca

Fax: (833) 615-1113

Clinical Director Dr. Michael A. Forrester, MD, PhD, FRCPC, FAAP

Provider Details (required):

☐ Midwife ☐ Nurse Practitioner ☐ Doctor

Name

Billing Number

Address

Date of Referral

Phone

Fax

Signature

Please inform client of EMAIL booking notifications.

Please complete all required fields.

Preferred IBCLC*:

IBCLCs are listed online OntarioBreastfeedingClinic.ca

*Clients may request a specific IBCLC, or next available appointment.

Link to INTAKE FORM will be emailed to client and MUST BE COMPLETED BY CLIENT before their appointment is booked.

OBC Clinic Hours:
Monday - Friday 9am-5pm
Closed STAT Holidays

Reason for Referral (required)

*Maternal issues directly related to infant feeding and nutrition

☐ Milk supply*
☐ Breast/nipple pain*
☐ Previous breast surgery*
☐ Pumping breastmilk difficulties*
☐ Multiple gestation*

Text

☐ PRENATAL* lactation education
PLEASE ENTER EDD
MM/DD/YYYY

☐ Latching difficulties
☐ Slow weight gain
☐ Prematurity
☐ Tongue tie
☐ Thrush/candida

☐ Other:

☐ Formula intolerance
☐ Disabilities
☐ Colic
☐ Weaning

Additional History:

Infant* (required, n/a if prenatal):

*Multiple? Please complete a referral for each baby

Name

Sex

DOB

Health Card Number

VC

Address

Lactating Parent (required)

Name

DOB

Health Card Number

VC

Email USED FOR BOOKING NOTIFICATIONS

Mobile phone ONLY