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.

Please select an IBCLC:

- ☐ Amanda Antal IBCLC
- ☐ Bethany Heintz RPN, IBCLC
- ☐ Ashley Pickett IBCLC
- ☐ Fara Patterson BAH, RN BScN, IBCLC
- ☐ Jandy Bersford IBCLC
- ☐ Camilla Aviss RN, BHSc(N), IBCLC, PMH-C
- ☐ No preference

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*

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

- ☐ Formula intolerance
- ☐ Disabilities
- ☐ Colic
- ☐ Weaning

☐ Other:

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

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