



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.

| | |
|--|---|
| <p>Please select a location:</p> <p><input type="checkbox"/> Amanda Antal IBCLC London/Norfolk</p> <p><input type="checkbox"/> Bethany Heintz RPN, IBCLC Waterloo/Wellington</p> <p><input type="checkbox"/> Ashley Pickett IBCLC Oakville/Mississauga</p> <p><input type="checkbox"/> Fara Patterson RN BScN, IBCLC Scarborough</p> <p><input type="checkbox"/> Jandy Bersford IBCLC Durham</p> | <p>Reason for Referral (required)</p> <p>*Maternal issues directly related to infant feeding and nutrition</p> <p><input type="checkbox"/> Milk supply*</p> <p><input type="checkbox"/> Breast/nipple pain*</p> <p><input type="checkbox"/> Previous breast surgery*</p> <p><input type="checkbox"/> Pumping breastmilk difficulties*</p> <p><input type="checkbox"/> Multiple gestation*</p> <p><input type="checkbox"/> Latching difficulties</p> <p><input type="checkbox"/> Slow weight gain</p> <p><input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> Tongue tie</p> <p><input type="checkbox"/> Thrush/candida</p> <p><input type="checkbox"/> Formula intolerance</p> <p><input type="checkbox"/> Disabilities</p> <p><input type="checkbox"/> Colic</p> <p><input type="checkbox"/> Weaning</p> <p><input type="checkbox"/> Other:</p> <p>Additional History:</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> PRENATAL* lactation education PLEASE ENTER EDD MM/DD/YYYY</p> <p><input type="text"/></p> |
|--|---|

| | |
|---|---|
| <p>Infant* (required, n/a if prenatal):</p> <p>*Multiple? Please complete a referral for each baby</p> <p>Name <input type="text"/> Sex <input type="text"/> DOB <input type="text"/></p> <p>Health Card Number <input type="text"/> VC <input type="text"/></p> <p>Address <input type="text"/></p> | <p>Lactating Parent (required)</p> <p>Name <input type="text"/> DOB <input type="text"/></p> <p>Health Card Number <input type="text"/> VC <input type="text"/></p> <p>Email USED FOR BOOKING NOTIFICATIONS <input type="text"/></p> <p>Mobile phone ONLY <input type="text"/></p> |
|---|---|