BREASTFEEDING MEDICINE OF KW

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New Vision Family Health Team
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Breastfeeding Medicine Referral Form

Date: _____

Affix Mother's Label Here	Affix Infant's Label Here
	Is this baby rostered? Y/N

Reason for Referral:

- ○ Antenatal
- ○ Poor/Slow Weight Gain
- ○ Tongue Tie Evaluation
- ○ Latching Difficulty
- ○ Breast/Nipple pain
- ○ Engorgement/Blocked Ducts
- ○ Low Milk Supply
- ○ Induced Lactation
- ○ Other

Urgency of Referral:

☐ Emergency (24hr) ☐ Urgent (2-3 days) ☐ Routine (1-2 wks)

Referring Physician/NP/Midwife:

Name:_____ Billing #:_____
Address:_____
Phone:_____ Fax:_____

Please Fax to: 519-578-6040
We will call patient for an appointment