| Mother's name: | Baby's name: |
|---|---|
| Mother's AHC#: | Baby's AHC#: |
| Mother's D.O.B.: | Baby's D.O.B.: |
| Mother's address: | Mother's phone number: |

# SCPCN/ Circle Medical Breastfeeding Clinic

## *Referral Form – please fax (726-0579)*

| Date | Clinic Name |
|---|---|
| Referring Physician/ Registered Nurse | Phone |
| Address | Fax |

**Urgency of referral**

- Urgent (within 1-3 days)
- Semi-urgent (within 7 days)
- Non-urgent (1-2 weeks)

**Reason for referral** (please check all applicable):

- Latching difficulties
- Nipple pain
- Nipple yeast or oral thrush in baby
- Anterior tongue tie
- Posterior tongue tie
- Low milk supply
- Engorgement
- Mastitis
- Overactive Milk Supply
- General breastfeeding advice and education
- Other:_____________________________

**Strategies tried to date:**

**Patient's medical history:**

**Current medications and medication allergies:**

**Please state which referral path you would prefer:**

- Assessment and treatment by a registered nurse lactation consultant +/- involvement with a physician trained in breastfeeding medicine if necessary (usual referral pathway)
- Direct consult with a Physician. Please explain_______________________________________

**Signature:** _____________________________________