

Doctor's Breastfeeding Clinic Referral Form: Fax to 905-230-8700**Mother's Name:** _____ **DOB:** _____

Health Card: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Baby's Name: _____ **DOB:** _____

Health Card: _____

Birth weight: _____ Other weights: _____

Name of Referring Provider: _____ **Phone:** _____ **Fax:** _____Address: _____ **CPSO #:** _____ **Billing #:** _____Signature of Referring Provider: _____ **Date (dd/mm/yy):** _____

Stamp:

REASON FOR REFERRAL: ☐ Normal ☐ Urgent