Place Patient Form Label Here

SPH BREASTFEEDING MEDICINE CLINIC OUTPATIENT CONSULT

Lactation Referral

DATE OF REFERRAL: ____________________________

PATIENT INFORMATION

Mother's Name: ____________________________

Mother's PHN: ____________________ DOB: (dd/mmm/yyyy) ____________________

Telephone: ____________________ Email: ____________________

Infant A Name: ____________________ DOB: (dd/mmm/yyyy) ____________

Infant B Name: ____________________ DOB: (dd/mmm/yyyy) ____________

Delivered at: (Hospital) ____________________ (City) ____________________

Primary Health Care Provider: ____________________________

Telephone: ____________________

REFERRING Physician / Registered Midwife / Nurse Practitioner

Name: ____________________ Signature: ____________________ MSP Billing: ____________

Contact number: ____________________ Fax number: ____________________

REASONS FOR REFERRAL (check all that apply)

MATERNAL:

- ☐ History of low milk supply
- ☐ Gestational Diabetes requiring insulin
- ☐ Type 1 Diabetes
- ☐ Previous breast surgery
- ☐ Severe postpartum hemorrhage
- ☐ Multiples birth
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Lactation suppression
- ☐ Maternal request
- ☐ Complex care patients as per care plan
- ☐ Nipple trauma

Other: ____________________

NEWBORN:

- ☐ Prematurity: less than 36+6 weeks GA
- ☐ Transition from bottle to Breastfeeding/ NG to Breastfeeding
- ☐ Weight loss of greater than 8% on day 1
- ☐ Newborn oral assessment (tongue tie, disorganized or poor suck)
- ☐ Treatment of hypoglycemia
- ☐ Small for gestational age (SGA) or Intrauterine growth restriction (IUGR)
- ☐ Re-admit Jaundice
- ☐ Not latching (more than 24 hours old)

Other: ____________________

ADDITIONAL INFORMATION

Fax completed form to 604-806-9081. Patient will be contacted directly to book an appointment.

Because of high demand for outpatient consults, first priority will be given to patients who delivered at St. Paul's hospital.