DR LINDSAY WEBSTER
MEDICAL TREE CLINIC
805 Blackburn Mews
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BREASTFEEDING ASSESSMENT (Antepartum and Post-partum) REFERRAL FORM

****Please provide both parent and infant info for complete referral****

Request date:	Appointment Date/Time:
For **Urgent** referral please fax form and call (613)887-8733	
Lactating Parent	**Infant**
Name:	Name:
Health Card #:	Health Card #:
DOB:	DOB:
Address:	
Phone Number:	
Alt. Phone Number:	

Referring Physician/NP/Midwife:		
Name:		Phone:
Billing no:		Fax:
Signature:		Are you in a FHO/FHT?: Yes ☐ No ☐

Referral reason(s): (check all that apply)	
☐ Antepartum: _____	☐ Latching difficulty
☐ Tongue-tie assessment/release	☐ Nipple pain
☐ Weight gain	☐ Engorgement/blocked ducts/mastitis
☐ Low milk supply	☐ Overproduction of milk
☐ Other: _____	

Patient's medical history:		Baby Weight (grams)	Date
	Birth		
	Discharge		
	Current		
G__T__P__A__L__ EDC:_____	Baby complications (NICU etc):		
Method of delivery:			
Gestation at birth:			
Prenatal history:			
Current Medications and Allergies:			