THE MILK CLINIC
INFANT FEEDING CENTRE

LACTATION MEDICINE REFERRAL FORM

***** Referrals are accepted from physicians, RM, NP, RN and Social Workers*****

PATIENT INFORMATION

Parent Demographics
Name____
DOB_____________ Age ______
PHN____
☐ Indigenous Pronouns___________

Infant Demographics (if applicable)
Name____
DOB____
PHN____

Contact Information
Email _______________________________________
Phone _______________________________________

REFERRING PRACTITIONER

Name ____
MRP(if different) ___________________________________
Title (NP, RM, MD, RN) ____ Billing # _______________
Date of Referral __________ Fax # __________________

URGENCY	PATIENT STATUS	LOCATION
☐ Urgent (72hrs)	☐ ANTENATAL; EDD ___________	☐ VIRTUAL
☐ ROUTINE (1wk)	☐ POSTPARTUM	☐ IN-PERSON (Penticton, BC)
☐ NON-URGENT (2+ wks)		

REASON FOR REFERRAL

- ☐ Anticipatory support: ____
- ☐ History of challenges: ____
- ☐ Current Challenges: ____
- ☐ Risk Factors present: ____
- ☐ Patient Request: ____

ADDITIONAL INFORMATION (eg birth and most recent weight, feeding hx)

Fax completed form to 833-844-6455

(Or 778-646-2557 for referrals in the South Okanagan)

Families will be contacted directly with appointment information

Appointments covered by MSP from pregnancy to 6 weeks postpartum