

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				
	meRP(if different)		Date of Referral Fax #	
URGENCY	PATIENT STATUS		LOCATION	
□ Urgent (72hrs)□ ROUTINE (1wk)□ NON-URGENT (2+ wks)	☐ ANTENATAL; ☐ POSTPARTUN	EDD	□ VIRTUAL□ IN-PERSON (Penticton, BC)	
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