Thunder Bay District Health Unit

Lactation Services Referral Form

Place Patient Label Here

(If applicable)

Date:

BREASTFEEDING/CHESTFEEDING PARENT	Prenatal Referral ☐ EDC:_____
Last Name:_____	**INFANT**
First Name:_____	Last Name:_____
DOB:_____ (YYYY-MM-DD)	First Name:_____
Phone: (H)_____ (C)_____	DOB:_____Gestation: _____
Address:_____	M☐ F☐
City:_____ Postal Code:_____	**If known:**
Partner/support person name:_____	Birth Weight:_____ Discharge Weight:_____
FP/MW/NP:_____	Discharge Date:_____
	Birth/Delivery concerns (if known):
	_____

Reason(s) for referral:

☐ Difficulty latching/not latching
☐ Milk supply issue/concern
☐ Medical concern – parent
☐ Premature
☐ Nipple or breast pain
☐ Supplements
☐ Medical concern – child
☐ Other
☐ Infant weight loss
☐ History of breast surgery
☐ Parent/child separation

Comments:

Level of Support Needed:

Low ☐ Moderate ☐ High ☐

Signature of Referring Provider:

PLEASE FAX REFERRAL FORM TO (807) 628-8664 FOR BOOKING

Personal information is collected under the authority of the *Health Protection and Promotion Act* and related legislation and in accordance with the *Personal Health Information Protection Act and/or the (Municipal) Freedom of Information and Protection of Privacy Act.* We collect only the information needed to provide public health programs and services and to plan and evaluate our services. The information may be shared with others as required or permitted by law. For more information contact TBDHU Lactation Services at (807) 625-8827 or visit our website at www.tbdhu.com/privacy-statement.