



Physician Group REFERRAL FORM

OntarioBreastfeedingClinic.ca

Fax: (833) 615-1113

Clinical Director Dr. Michael A. Forrester, MD, PhD, FRCPC, FAAP

Provider Details (required):

☐ Midwife

☐ Nurse Practitioner

☐ Doctor

Name

Billing Number

Address

Date of Referral

Phone

Fax

Signature

***Please inform client of EMAIL booking notifications.**

Please complete all required fields.

Preferred IBCLC*:

IBCLCs are listed online
OntarioBreastfeedingClinic.ca

*Clients may request a specific
IBCLC, or next available appointment.

Link to INTAKE FORM will be emailed
to client and MUST BE COMPLETED
BY CLIENT before their appointment
is booked.

OBC Clinic Hours:
Monday - Friday 9am-5pm
Closed STAT Holidays

Reason for Referral (required)

*Maternal issues directly related to
infant feeding and nutrition

- ☐ Milk supply* ☐ Breast/nipple pain* ☐ Previous breast surgery*
☐ Pumping breastmilk difficulties* ☐ Multiple gestation*

☐ PRENATAL* lactation education
PLEASE ENTER EDD
MM/DD/YYYY

- ☐ Latching difficulties
☐ Slow weight gain
☐ Prematurity
☐ Tongue tie
☐ Thrush/candida

- ☐ Formula intolerance
☐ Disabilities
☐ Colic
☐ Weaning

☐ Other:

Additional History:

Infant* (required, n/a if prenatal):

*Multiple? Please complete a referral for each baby

Name Sex DOB

Health Card Number VC

Address

Lactating Parent (required)

Name DOB

Health Card Number VC

Email USED FOR BOOKING NOTIFICATIONS

Mobile phone ONLY