Blume Maternity Care
Unit #201 — 15149 BC-10
Surrey, BC V3S 9A5
Phone: 604 — 200 — 3759
Fax: 236 — 260 — 0856
www.blumematernitycare.ca
PLEASE FAX THIS REFERRAL FORM TO US!

LACTATION CONSULTATION REFERRAL FORM

PATIENT INFO:	NEWBORN INFO:
Full Name: _____	***Full Name:*** _____
Date of Birth: _____	***Date of Birth:*** _____
PHN: _____	***Sex:*** ▢ Male ▢ Female
Phone Number: _____	***Gestational Age at Birth:*** _____
Email: _____	***Birth Weight:*** _____ grams
Home Address: _____ _____	***Current Weight (If Known)*** _____ grams

Preferred Language: _____

Interpreter Required: ▢ Yes ▢ No

FEEDING HISTORY & CONCERNS
Primary reason for referral:
- ▢ Latching Difficulty
- ▢ Pain with Latching
- ▢ Low Milk Supply
- ▢ Infant Weight Concerns
- ▢ Pumping Questions
- ▢ Antenatal Education
- ▢ Other _____

PARENT MEDICAL HISTORY
Check all that apply:
- ▢ PCOS
- ▢ Thyroid Disorder
- ▢ Diabetes
- ▢ Anemia
- ▢ Breast Surgery (Type): _____
- ▢ History of Low Milk Supply
- ▢ Mental Health Concerns (i.e., PPD, Anxiety, etc.)
- ▢ Other _____

INFANT HEALTH CONCERNS
Check all that apply
- ▢ Jaundice
- ▢ NICU Stay
- ▢ Reflux
- ▢ Tongue Tie or Lip Tie
- ▢ Prematurity
- ▢ Allergies/Suspected Intolerances
- ▢ Other _____

REFERRING PROVIDER (MD, RN, NP, RM, RSW):

Name: _____

MSP #: _____

Signature: _____

Date: _____