A WISE BEGINNING

referral form

LACTATION SUPPORT

Date of Submission

PREFERRED VISIT TYPE

☐ In Person ☐ Virtual

MOTHER/BIRTHER'S INFORMATION

Full Name (as it appears on care card)

Date of Birth (dd-mmm-yy)

Personal Health Number

Address

Phone Number

Email Address

Baby's Name

Baby's Date of Birth (dd-mmm-yy)

Baby's Birth weight

Baby's most recent weight & date

Please review our catchment area on our website. We offer care in areas of North Delta, Surrey and White Rock. If you are outside of our catchment area, you will be offered a virtual visit.

REASONS FOR REFERRAL

PARENT

Check all that apply:

- ☐ Low milk supply
- ☐ Mastitis
- ☐ Engorgement/oversupply
- ☐ Multiple gestation
- ☐ Breast/nipple pain
- ☐ Inverted nipples
- ☐ Fast letdown
- ☐ Diabetes
- ☐ Clogged ducts
- ☐ Pumping difficulties
- ☐ Previous breast surgery
- ☐ PCOS

INFANT

Check all that apply:

- ☐ Weight loss >8-10%
- ☐ Poor/disorganized suck
- ☐ Hypoglycemia
- ☐ Slow weight gain
- ☐ Breast refusal
- ☐ Jaundice
- ☐ Shallow/ineffective latch
- ☐ Gassy/irritable
- ☐ Tongue tie

NOTES

Please provide any additional information or notes here.

Please forward completed intake form to awisebeginning@gmail.com
Your patient/client will be contacted directly.

thank you!