A WISE BEGINNING

referral form

LACTATION SUPPORT

Date of Referral

PROVIDER INFORMATION (required for MSP coverage*)

Referring Provider

Office/Clinic Name

MSP #

Office Email Address

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 note: MSP coverage is only available until baby is 42 days old if the birthing parent has MSP coverage.**

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 referral to awisebeginning@gmail.com
Your patient/client will be contacted directly.
If they are outside of our catchment area as described on our website, they will be offered a virtual visit.

thank you!