Grow Infant Feeding Centre
Grace Jeun, RM IBCLC
Candace Plohman, RM IBCLC
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REFERRAL FORM

Patient Information

Patient Name: _____

PHN: _____ DOB: (Day/Month/Year) _____

Address: _____ City: _____

Phone number: _____ Email: _____

Care Provider Information

Doctor/Midwife/NP Name:_____ MSP#: _____

Phone: _____ Fax: _____

Reason for referral:

- ☐ IBCLC breast/chest feeding support in home or office (Lactation Consult)
- ☐ Midwifery full postpartum care until 6wks - home and office (Midwifery Consult)
- ☐ Other: _____

_____

Relevant History:

Infant's Birth date: (Day/Month/Year) _____/_____/_____

Birth weight: _____ g

Today's date: _____/_____/_____ Current weight: _____ g

Mode of delivery (SVD, c-section, vacuum, forceps): _____

**Please attach Labor and Birth Summary, Newborn 1&2, labs, or other relevant information.*

Care is ONLY available up to 6 weeks postpartum in tri-cities, and surrounding areas.

Thank you for the referral. A summary will be forwarded to you once care is complete.