Referral - ELMIRA, Ontario Breastfeeding Clinic

Ontario Breastfeeding Network
my-obn.ca
OntarioBreastfeedingNetwork@gmail.com

Quick Care Pediatrics
QuickCare-Pediatrics.com
QuickCarePaediatrics@gmail.com
Fax 519-512-0051

Health Care Provider Details
Doctor, Midwife or Nurse Practitioner

Name (first and last) _____ Ohip Billing Number _____

Practice Name and Address

_____

Fax _____ Phone _____

Email _____

Signature _____ Date of Referral _____

Timeframe patient should be seen within _____

Patient Contact Details
Infant's Name (first and last) or indicate Prenatal _____

Date of Birth (EDD if prenatal) (M/D/YYYY) _____ Sex (M/F/X) _____

Mother/Parent's Name (first and last) _____

Text/Phone _____ Email _____

Address _____

Reason for Referral (please indicate)

Prenatal Breastfeeding Class	Engorgement	Baby always hungry
Latch difficulties	Breast pain	Non-latching
Sore nipples	Mastitis	Low weight gain
Bleeding/Cracked nipples	Milk Supply	Pumping/expressing

Other/Additional:

Appreciated
Please Attach Relevant Health History