Community
Infant Feeding Centre

#200-1193 Kingsway
Vancouver, BC V5V 3C9

Phone: 604.324.2201
Fax: 604.324.2205

Lactation Consultant Referral Form

REFERRAL DATE: _____

(month/day/year)

FEEDING PARENTS NAME: _____ _____

(as presented on BC Services card) (first) (last)

DATE OF BIRTH: _____ **PHN:**_____

(month/day/year)

HOME ADDRESS: _____

CITY: _____ **PROVINCE**: _____ **POSTAL CODE:** _____

PHONE: _____(_____)_____-_____

EMAIL ADDRESS: _____

BABY'S NAME:_____ **BABY'S DATE OF BIRTH:**_____

(month/day/year)

REASON FOR REFERRAL (✔tick all that apply):

☐ Shallow Latch	☐ Mastitis	☐ Baby Rejecting Nipple
☐ Pain with latching/feeds	☐ Slow infant weight gain	☐ Infant Feeding Plan including pumping/formula
☐ Low Milk Supply	☐ Breast/Nipple Discomfort	☐ History of Breast Surgery
☐ Engorgement/Over supply	☐ Premature Baby	☐ Twins/Multiples
☐ Inverted Nipples	☐ Cleft Palate	☐ Clogged ducts
☐ Fast letdown	☐ Tongue Tie	

ADDITIONAL INFORMATION:

Referring Practitioner:_____ **MSP #:**_____

Phone:_____(_____)_____-_____ **Fax:** _____(_____)_____-_____

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Please fax completed form to: 604-324-2205

Questions? Email us at: infantfeedingcentre@gmail.com

SOUTH COMMUNITY BIRTH PROGRAM