CMC | CORNERSTONE MEDICAL CLINIC

#100-415 Wellman Crescent
Saskatoon, SK, S7T 0J1
Ph 306-975-1262 Fax 306-975-1221

BREASTFEEDING MEDICINE REFERRAL FORM

PATIENT INFORMATION

Surname: _____ First Name: _____

Birthdate: ___/___/_____ (DD/MM/YYYY) PHN: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

Baby's Name: _____ Baby's PHN: _____

Baby's Birthdate: ___/___/_____ (DD/MM/YYYY)

REFERRING PRACTITIONER INFORMATION

☐ Family Doctor Referring Practitioner: _____
☐ Specialist Clinic: _____
☐ Nurse Address: _____
☐ Other: _____ Phone: _____ Fax: _____

COMMON REASONS FOR REFERRAL (*please check all that apply)*

☐ Pregnant patient with previous difficulty breastfeeding, or breast surgery
Due Date: ___/___/_____ (DD/MM/YYYY)
☐ Latching difficulties
☐ Low milk supply +/- need for galactogogues (Rx to increase milk supply)
☐ Engorgement or overactive milk supply
☐ Breast or nipple pain
☐ Suspected infection or mastitis
☐ Inducing lactation (adoption, surrogacy, non-child bearing female partner)
☐ Medical condition — mother, specify: _____
☐ Medical condition — baby, specify: _____
☐ Tongue or lip tie evaluation +/- treatment
☐ Poor/slow weight gain in breastfed infant
☐ Breastfeeding twins/triplets or tandem breastfeeding
☐ Breast pump education/trouble shooting
☐ Other breastfeeding concerns/questions: _____
_____

Practitioner Signature: _____ Date: ___/___/_____ (DD/MM/YYYY)

Please fax referral form to 306-975-1221

See our website www.cornerstonemedical.ca for more information.