REFERRAL FORM FOR MSP-COVERED LACTATION CONSULTATIONS

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MSP: 89350 BCCNM: 1353 L-303437

Patient name: _____ Baby's name: _____
DOB: _____ DOB: _____
PHN: _____
Address: _____
Phone: _____
Email address: _____

Referring practitioner: _____
MSP: _____
Phone: _____
Fax: _____

Prenatal or postpartum consult? _____

Reason for referral: _____
_____
_____
_____

Patient's current medications/allergies: _____
_____

Relevant medical/birth history:
_____
_____
_____

Infant birth weight (g): _____
Discharge/most recent weight: _____
Gestational age at birth: _____

Note:
* This service is provided antenatally and up to six weeks postpartum.
* Patients will be contacted directly for consults.
* Consults are available at home, telehealth or clinic, depending on availability.