

Well Fed Clinic - East
M009 2675 36 St NE
Calgary AB T1Y 6H6
P: 403-513-7415 F: 587-387-2918



Well Fed Clinic - West
#130, 1402 8 Ave NW
Calgary, AB T2N 1B9
P: 403-303-3727 F: 1-888-676-4641
** Temporary location until Spring 2025**

Breastfeeding and Infant Feeding Assessment Referral Form

Please fax to the patient's preferred location

Date: _____

Urgency of Referral:	<input type="radio"/> Urgent (within 24 hours)	<input type="radio"/> Semi-Urgent (within 2-7 days)
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**Affix Infant Information
label here**

**Affix Mother Information
label here**

Preferred Phone #:	Family Physician:
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Referring Physician/NP/Midwife:

Name:	Phone:
Practice ID:	Fax:
Signature:	Site:

Issues to be addressed (Check all that apply):

<input type="radio"/> Antenatal	<input type="radio"/> Latching Difficulty
<input type="radio"/> Tongue-Tie/Lip-Tie	<input type="radio"/> Nipple Pain
<input type="radio"/> Weight Gain	<input type="radio"/> Engorgement/Blocked Ducts
<input type="radio"/> Low Milk Supply	<input type="radio"/> Other _____

Patient's medical history (include baby's birth weight and most recent weight):

Current medication and medication allergies:

Our office will contact the patient directly to book an appointment

For medical clinic only	
Confirmed booked appointment Date: _____	Time: _____