Well Fed Clinic - East
M009 2675 36 St NE
Calgary, AB, T1Y6H6
P: 403-513-7415
F: 587-387-2918

Well Fed Clinic - West
#308, 4935 40th Ave, Calgary,
AB, T3A 2N1
P: 403-303-3727
F: 888-676-4641

Breastfeeding and Infant Feeding Assessment Referral Form

Please fax to the patient's preferred location

Date: _____

Urgency of Referral:	◯ Emergent	◯ Urgent	◯ Semi Urgent

Affix Mother Information Label Here	Affix Infant Information Label Here

Language Line Needed? YES / NO	Langauge:	Preferred Phone #:

Email:	Family Physician:

Primary phone belongs to: □ Self □ Spouse/Partner □ Parent □ Sibling □ Cousin □ Other: _____

Referring Physician/NP/Midwife:

Name:	Phone:
Prac ID:	Fax:
Signature:	Site:

Issues to be addressed (Check all that apply):

◯ Antenatal - EDD:	◯ Weight Gain	◯ Engorgement/ Blocked Ducts
◯ Tongue Tie	◯ Low Milk Supply	◯ Latching Difficulty
◯ Lip Tie	◯ Nipple Pain	◯ Other: _____

Received Vitamin K? YES / NO	If yes: IM / Oral	How Many Doses:

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

Current Medication and medication allergies:

Our office will contact the patient directly to book an appointment