Lactation Support Referral

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Please submit completed form to:
referrals@TheTinyHumanCo.com
Fax: 519-964-8511

Referring Professional

Name:	
Address:	
Phone Number:	
E-Mail (if applicable):	
Fax:	
Designation	◯ Midwife ◯ Physician ◯ Nurse Practitioner
OHIP Billing Number:	

Baby's Information

Name:	
Address:	
Date of Birth:	
OHIP Number:	

Lactating Parent's Information

First & Last Name:	
Date of Birth:	

Address:	
E-Mail: (for appointment booking)	
Cell Phone Number: (for appointment confirmation)	
OHIP Number & Version Code:	

Reason for Referral

- ☐ Low Milk Supply
- ☐ Painful Latch
- ☐ Slow Weight Gain
- ☐ Cracked/Bleeding Nipples
- ☐ Tongue Tie Assessment
- ☐ Latching Difficulties
- ☐ Recurrent Mastitis / Plugged Ducts
- ☐ Difficulty with Pumping

Additional Information:

Your client will be contacted directly via. text or e-mail to schedule an appointment time.