Norfolk Prenatal and Newborn Health Program
105 Main Street
Delhi, ON N4B 2L8
Phone: 519-582-2323 ext. 282
Fax: 519-582-1513

NORFOLK FAMILY HEALTH TEAM
Your well-being is our Primary care

Referral Form – Postpartum and Well Baby Care/Lactation Consultant

☐ **Postpartum and Well-Baby (newborn up to 2 months of age)**

☐ **Lactation Consultant Only (any breastfeeding concerns up to and including weaning)**

_____ _____
Mother's Name (First and Last) Infant's Name (First and Last)

_____ _____
Mother's Health Card Number Infant's Health Card Number

_____ _____
Mother's DOB Infant's DOB

_____
Address Unit City Postal Code

_____ _____
Phone Number Family Doctor

SVD/Forceps/Vacuum/Cesarean Section:_____

Infant's birth weight: _____

Infant's most recent weight: _____ Date of most recent weight? _____

Reason for Referral (and any clinical concerns)

_____
_____

Current Medications: Please list.

_____
_____

Date of Referral: _____

Referring Person: _____

Address/Phone/Fax Number: _____

_____

Please attach any relevant health records (ie. Bili, labs, prenatal records, birth records, newborn records)

Thank you. We will contact your patient to book an appointment.

Administration Only
Eligible for Program? _____ Appointment Booked? _____