MONARCH
MATERNAL AND NEWBORN HEALTH

Referral Form

Referring providers can fax the completed form to 613-226-7059.

PATIENT INFORMATION	
PARENT	**INFANT**
*Name:	***Name:**
*OHIP #:	***OHIP #:**
*DOB:	***DOB:** ***Gestational age:**
*Phone #:	***Birth weight:**
Alternate phone #:	***Most recent weight:** Date:
*Address:	***Place of birth:** TOH Civic ☐ TOH General Other:
*Email:	***Bilirubin:** @ Date: Time:

REFERRING PROVIDER	
*Name:	***Address:**
*Clinic/group:	***Phone #:**
*OHIP #:	***Fax #:**

REASON FOR REFERRAL		
JAUNDICE ASSESSMENT		
Did the infant have phototherapy? Yes No Hospital: Date started:		
Risk Factors: DAT positive/antibodies Weight loss >10% Cephalohematoma/bruising Sibling had phototherapy Ethnicity: Other:		
PHYSICIAN BREASTFEEDING/ LACTATION CONSULT (COMPLETE PAGE 2)		
Note: Consults for breastfeeding/lactation medicine are for parent-baby dyads with complex medical challenges impacting feeding. For non-medically complex cases, please refer to community lactation consultants.		
OTHER/COMMENTS		

ADDITIONAL INFORMATION FOR BREASTFEEDING/LACTATION MEDICINE REFERRALS

Type of Consult

Postpartum Prenatal Estimated Due Date:

Current Feeding (select all that apply)

Breast Pumped milk Formula Other:

Indications for consult (select all that apply):

Pain with breastfeeding:

Breast/nipple infection Recurrent blocked ducts Vasospasm

Mastitis/Abscess Other:

Hyperlactation

Low milk production (not responding to increased breast stimulation/pumping 6+ times/day).
Note: ECG suggested if domperidone is being considered.

Suboptimal infant weight gain

Induced lactation

Medical condition or medication concern (provide details below)

Parent Baby

Other:

Please provide additional information on medical conditions/medications. Include relevant medical and pregnancy history, allergies, and medications.

Attach infant growth charts/weights, relevant breast imaging, or other investigations and notes.