



GREEN MOUNTAIN
Midwifery & Lactation Consulting
Carlie Sanford RM, IBCLC

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REFERRAL FORM

Patient Name:

Address:

DOB:

PHN:

Phone number:

Referrer Name:

MSP:

Phone:

Fax:

Reason for referral:

- IBCLC Breast/Chestfeeding support in home and Telehealth combined
- Contraception Counselling/prescribing (telehealth)
- Midwifery Postpartum home visit (maternal and infant general exam)
- Antenatal breast/chestfeeding consultation (1 hr prenatal in person or telehealth)

Relevant History:

Please attach a summary of birth hx, newborn info, labs, or other relevant information to care.

Care is only available up to 6 weeks postpartum in burnaby, and tri-cities areas.

Thank you for the referral! A summary will be forwarded to you once care is complete.