Greenway Midwifery & Lactation Consulting
Grace Jeun, RM, IBCLC
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REFERRAL FORM

Patient Information

Patient Name: ______________________________

PHN: ____________________ DOB: (Day/Month/Year) ____________________

Address: ____________________ City: ____________________

Phone number: ____________________

Care Provider Information

Doctor/Midwife/NP Name: ____________________ MSP#: ____________________

Phone: ____________________ Fax: ____________________

Reason for referral:

☐ IBCLC breast/chest feeding support in home or office (Lactation Consult)
☐ Midwifery full postpartum care until 6wks - home and office (Midwifery Consult)
☐ Other: ______________________________
____

Relevant History:

Infant's Birth date: (Day/Month/Year) ________/________/________

Birth weight: ____________ g

Today's date: ________/________/________ Current weight: ____________ g

Mode of delivery (SVD, c-section, vacuum, forceps): ____________________

**Please attach Labor and Birth Summary, Newborn 1&2, labs, or other relevant information.*

*****Care is ONLY available up to 6 weeks postpartum in tri-cities, and surrounding areas.***
Thank you for the referral. A summary will be forwarded to you once care is complete.