REFERRAL FORM

Referral Date: _____

Breastfeeding Parent's Name:_____
DOB: _____Health Card #: _____VC: _____
Address: _____
_____Phone #: _____

Reason for Referral:
_____
_____
_____
_____
_____
_____

Referring Practitioner(printed name):_____Billing #: _ _ _ _ _ _
Address: _____
Phone #: _____ Fax #: _____

NOTE:
*Referrals can only be made by Medical Doctors, Midwives or Nurse Practitioners
*Incomplete referrals will be returned to your office
* Appointment request must be submitted by patients at www.ibconline.ca

Please fax completed form to the number below.

1255 Sheppard Avenue East • Toronto, ON Canada • M2K 1E2
www.ibconline.ca • clinic@ibconline.ca
Phone: 416-498-0002 fax : 416-498-0012