REFERRAL FORM

Referral Date: ___________________________

Breastfeeding Parent's Name:____
DOB:________________Health Card #:_______________________VC:______
Address: ____
_______________________________Phone #: ___________________________

Baby's Name:____

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.

58A-2700 Dufferin St. Toronto ON, M6B4J3
www.ibconline.ca • clinic@ibconline.ca
Phone: 416-498-0002
Fax: 416-498-0012 or 416-352-1224