Norfolk Prenatal and Newborn Health Program
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Delhi, ON N4B 2L8
Phone: 519-582-2323 ext. 282
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NORFOLK FAMILY HEALTH TEAM
Your well-being is our Primary care

Self Referral Intake Form – Postpartum and Well Baby Care/Lactation Consultant

☐ **Postpartum and Well-Baby (newborn up to 2 months of age)**

☐ **Lactation Consultant Only (any breastfeeding concerns up to and including weaning)**

_____ _____
Mother's Name (First and Last) Infant's Name (First and Last)

_____ _____
Mother's Health Card Number Infant's Health Card Number

_____ _____
Mother's DOB Infant's DOB ☐ Female ☐ Male

_____
Address Unit City Postal Code

_____
Phone Number Email Address for Ocean

SVD/Forceps/Vacuum/Caesarean Section: _____ Place of birth: _____G.A. _____

Infant's birth weight? _____

Infant's most recent weight_____ Date of most recent weight? _____

Reason for Referral (and any clinical concerns)

_____

_____

_____

Current Medications/Allergies.

_____

_____

Date of Referral: _____

Family Doctor: _____

Obstetrical Care Provider: _____

Administration Only
Eligible for Program? _____ Appointment Booked? _____