WILLOW
FAMILY MEDICINE

Dear colleague,

Our clinic is pleased to offer lactation & Infant feeding consultations with family physicians who hold additional certifications as International Board Certified Lactation Consultants, as well as members of the North American Board of Breastfeeding Medicine. This service is of no cost to patients with Alberta Health Care. If indicated, procedures such as lingual and labial infant frenectomy are available. Referrals are accepted from providers with an Alberta Practice ID number, including doctors, nurse practitioners, midwives, audiologists, chiropractors, podiatrists, dentists, optometrists, and physical therapists.

At this consultation, both the primary feeding parent and infant will be assessed - multiple aspects of feeding will be discussed, such as, but not limited to;

- Body mechanics
- Presence/absence of restricted oral tissue (lingual and labial frenulum)
- Physical and mental factors impacting breastfeeding
- Appropriateness of supplementation
- Need for medications to facilitate milk supply
- Current and past medical concerns

To refer patients;

- Fax referral for the primary feeding parent and infant to 1-780-665-2225
- If preferred, attached is a templated referral form
- Once received, your patient will be contacted via email and text to book an appointment using our online scheduler

I hope you and your patients find this helpful service. Please do not hesitate to contact me with any questions or concerns.

Sincerely,

Dr. Kelly MacGregor & Dr. Tanya Schuman

Kelly MacGregor MD CCFP IBCLC NABBLM-C
Tanya Schuman MD CCFP IBCLC
kellymacgregormd@gmail.com | www.willowfamilymedicine.ca | F. 780-665-2225 | P. 587-404-0570

Lactation & Infant Feeding Program Referral

****All fields mandatory - Incomplete referrals will be returned****

Fax to: 780 - 665 - 2225 | www.willowfamilymedicine.ca

Primary Feeding Parent Information

- Legal Name (Last/First):
- Date of Birth (Day/Month/Year):
- Sex:
- Provincial Health Care Number:
- Phone number:
- Email Address:

Infant Information ***(not required for prenatal program; however, required if dyad needs support in our postnatal program)***

- Legal Name (Last/First):
- Date of Birth (Day/Month/Year):
- Sex:
- Provincial Health Care Number:

Referring Provider Information (Referrals accepted from a doctor, nurse practitioner, midwife, audiologist, chiropractor, podiatrist, dentist, optometrist or physical therapist)

- Legal Name:
- Clinic Phone Number:
- Clinic Fax Number:
- Provider Prac-ID:
- Signature: _____ Date: _____

(or signature of allied health care provider sending on behalf of the above, thereby certifying verbal approval for referral was obtained)

Dear Drs. MacGregor & Schuman, thank you for seeing the above dyad regarding lactation and/or infant feeding challenges. Submission of this referral certifies the endorsement of the above-referring provider in the solicitation of the following help;

- ❏ Nipple pain/trauma
- ❏ Latch concerns
- ❏ Milk supply management
- ❏ Lactation after breast/chest surgery
- ❏ Slow infant weight gain
- ❏ Infant oral restrictions
- ❏ Brief history of problem(s):
- ❏ Other: