MONARCH

MATERNAL AND NEWBORN HEALTH

Referral Form

☐ **Monarch West**
152 Cleopatra Drive, Suite 108
Ottawa, ON K2G 5X2
Telephone: 613-627-0795
Fax: 613-226-7059

☐ **Monarch South East**
1355 Bank Street, Suite 104
Ottawa, ON K1H 8K7
Telephone: 613-691-2578
Fax: 613-226-7059

Request Date:	**Appointment Date/Time:**

The referring provider and patient will be contacted with details of the appointment. If you have not heard from the Monarch Centre within 24 hours, please contact the Monarch Centre and speak with one of our Care Coordinators. Please note that BOTH Mom AND Infant are assessed together

Mother	**Infant**	
Name:	Name:	
Health Card #:	Health Card #:	
DOB:	DOB:	
Address:	**Weight (grams)**	**Date**
	Birth:	
Phone Number:	Discharge:	
Alt. Phone Number:	Most recent:	

Referred By:

☐ Physician	☐ IBCLC	☐ Midwife	☐ Nurse	☐ Other

Health Care Provider:	Billing no:
Establishment:	Please check box if FHO/FHT ☐
Phone Number:	Fax Number:

Referral Reason(s)

☐ **Jaundice Assessment** (If yes, complete below)

Infant had phototherapy: ☐ No ☐ Yes
Date: Location:

Bilirubin	Age in Hours	Date

Place of Birth: ☐ TOH Civic ☐ TOH General
☐ Other (TSB ONLY done if TOH birth)

Gestational age:

Ethnicity:

☐ DAT positive/weak positive/antibodies
☐ Cephalohematoma/Bruising
☐ Sibling who required phototherapy
☐ Weight loss > 10%

☐ **Tongue Tie Assessment/Release**

☐ **Breastfeeding Assessment**
(check and circle applicable)

☐ Nipple Pain/infection/wound Rt/Lt
☐ Breast Pain/infection/lump Rt/Lt
☐ Latch Difficulty/non latching Rt/Lt
☐ Low milk supply
☐ Expressing/pumping breastmilk
☐ Supplement
☐ Breastmilk ☐ Formula
☐ Overproduction of Milk supply
☐ Medications:

☐ **Other Reason/Comments:**

Monarch Clinic Use ONLY

	Date	C. C.
Received:		
Patient Contacted:		
Provider Contacted:		

Comments: