Maple Kidz Clinic
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Dr. Saba Merchant, MD, FRCPC
& Associates

BREASTFEEDING REFERRAL FORM

DR. POOJA PRABHU, MD, FAAP, IBCLC

Referral Date:

Baby's name:
DOB: ☐ Male ☐ Female
Address:
Health Card #:
Phone number:

Breastfeeding Parent's name:
DOB:
Address:
Health Card#:
Phone number:

Reason for the referral:

Referring Provider:
Address:
Phone number: **Fax:**
Billing number:

Please fax completed form to 905-303-3035