

|  |  **TIP OF THE TONGUE****LACTATION CONSULTATION REFERRAL**80 300 Donlevy Avenue, Red Deer, AB403-391-1413 info@tipofthetongue.ca |
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 **Client Name**: First Name Last Name

 First Last

**Date of Birth:**  Year Month Day

 YR / MM / DD

**Parent Names:** Parent Name

**Mailing Address:** Mailing Address

City or Town Province Postal Code

**Phone Number:**  Phone Number

**Client Email Address:**  Email

**Reason for Referral/Comments (Please send client photos or current treatment plan**

**to** **info@tipofthetongue.ca** **along with this referral):**

| Click here to enter text. |
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**Referring Practitioner:** Click here to enter.

**Date of Referral:**  Click here to enter a date.

***Upon receipt of referral Tip of the Tongue will contact the client to schedule an appointment. Thank you for your referral and collaborative care for our clients.***

www.tipofthetongue.ca