Dr. Tehmina Amer
Ancaster Pediatric & Breastfeeding Clinic Referral Form

1144 Wilson St. W. Suite 103 Ancaster, Ontario L9G3K9
(Inside Ancaster Medical Centre)
Phone: 905-304-8017 | Fax: 905-304-8004
Email: ancasterpediatric@gmail.com

Urgent Referral: No

Service Requested:

☐ Pediatric Consultation

☐ Breastfeeding Consultation (LC: Basia Cook)
Please refer under baby & attach newborn record
Mother's Name: _____Mother's DOB: _____
Health Card #: _____ VC: ____

☐ Introduction to Solid Foods ☐ Infant/Toddler Sleep Consultation (0-3 years)

Pediatric Patient Information: Affix Label or Complete the Following:
Last Name: _____ First Name: _____
DOB: _____ Health Card #: _____ VC: _____
Phone: _____ Email: _____

Reason For Referral: *Please attach any relevant medical history including labs, imaging, hospital records, etc.

Referring MD: _____ MD Billing #: _____
MD Address: _____
Phone: _____ Fax: _____
Signature: _____ Date: _____

Please fax referrals to 905-304-8004
Incomplete referrals will not be processed.