FLOW
Tennessee's Center for Breastfeeding Medicine

Referral for Healthcare Providers

Please complete this referral form to coordinate care with Flow Breastfeeding. All information provided will be handled confidentially and in accordance with HIPAA regulations.

Provider Information

Provider's Name:

Provider's Practice Location:

Patient Information

Patient's Name:

Patient's Preferred Method of Contact:
☐ Phone ☐ Email ☐ Text Message
Details:

Referral Details

Reason for Referral:

Urgency:
☐ Routine — should be seen within 7 days
☐ Urgent — should be seen within 24–48 hours

Care Summary Communication

Would you like to receive a summary of our visit with your patient?
☐ Yes ☐ No

If yes, please provide a HIPAA-secure email address:
_____

Authorization

☐ By submitting this form, I affirm I am a healthcare provider or authorized member of the healthcare team.