



Hamilton

Public Health Services

FAMILY HEALTH DIVISION

REFERRAL TO LACTATION CONSULTANT

Health Connections: (905) 546-3550
Fax: (905) 628-6465

Parents' Names:
Mom's DOB:
Baby's Name:
Baby's DOB:
Address:
Phone:
MD/MW:

Date Referral Initiated:

Telephone:

Requested by: (please print)

Signature:

- checkbox RN, checkbox Physician, checkbox Pediatrician, checkbox Midwife, checkbox Nurse Practitioner, checkbox IBCLC, checkbox HCP

Date Mom & Baby Seen:

- checkbox Home Visit, checkbox Office, checkbox Phone Contact Only, checkbox Hospital, checkbox Other, checkbox ER

PLEASE SELECT THE APPROPRIATE REASONS FOR REFERRAL

- checkbox weight loss >= 10%, checkbox congenital newborn abnormalities, checkbox sore/cracked/bleeding nipples, checkbox previous difficulties with milk production, checkbox latch difficulties, checkbox management of: yeast, mastitis, blocked ducts, checkbox maternal issues - explain, checkbox slow to gain - explain, checkbox tongue-tie, checkbox supplementation for breast feeding difficulties, checkbox inverted nipples, checkbox suckling difficulties, checkbox multiple birth, checkbox breast reduction/surgery, checkbox low birth weight < 2500g, checkbox pre-term birth issues - gestation weeks, checkbox low/perceived low milk supply, checkbox use of lactation aids

OTHER INFORMATION

COMMENTS

Date Received