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: _____ Signature: _____
(please print)

❒ RN ❒ Physician ❒ Pediatrician ❒ Midwife ❒ Nurse Practitioner ❒ IBCLC ❒ HCP

Date Mom & Baby Seen: _____

❒ Home Visit ❒ Hospital ❒ ER
❒ Office ❒ Other: _____
❒ Phone Contact Only

PLEASE SELECT THE APPROPRIATE REASONS FOR REFERRAL

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

OTHER INFORMATION

_____

COMMENTS

_____

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_____

Date Received