Breastfeeding Support Referral Form

Date: _____

Mother's Name: _____ **Infant's Name:** _____

Mother's Age: _____ **Gestational Age:** _____ **weeks**

Parity: G _____ **P** _____ **Birth Weight:** _____ **grams**

Mother's Phone #: _____

History of Breastfeeding: ☐ **Yes** ☐ **No**

Referred by:

Name: _____ MD/DO, CNM, NP, PA, RN, LPN (circle one)

Address: _____

_____

Phone Number: _____

Reason for Referral:

- ☐ Mother/family interested in learning more about breastfeeding
- ☐ Difficulty with latch
- ☐ Poor milk supply

If you are concerned about infant weight, please schedule appointment for today or tomorrow

- ☐ Sore nipples or other breast problem
- ☐ Preparing to return to work/school
- ☐ Other: _____

Referred to:

- ☐ Lactation specialist
- ☐ WIC breastfeeding staff
- ☐ Newborn Home Visiting Program
- ☐ Nurse-Family Partnership
- ☐ Other: _____

My Appointment

Date: _____ **Time:** _____

Name: _____ **Phone Number:** _____

Address: _____

If you have any questions before your appointment, call: _____

NYC Health

Bill de Blasio
Mayor

Mary T. Bassett, MD, MPH
Commissioner

Patient Copy

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