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: ____________________________
Address: ______________________________________
____________________________________
Phone Number: ____________________________

Reason for Referral:
☐ Mother/family interested in learning more about breastfeeding
☐ Difficulty with latch
☐ Poor milk supply
☐ 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: ____________________________

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

Bill de Blasio
Mayor
Mary T. Bassett, MD, MPH
Commissioner

Patient Copy
Breastfeeding Support Referral Form

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<table>
<thead>
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<th>Mother’s Name: ____________________________</th>
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<th>Name: ____________________________</th>
<th>MD/DO, CNM, NP, PA, RN, LPN (circle one)</th>
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NYC Health

Bill de Blasio
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Chart Copy