

Referral for Lactation Visit with
[YOUR NAME, INITIALS AND PHONE NUMBER]

Mother's name: _____ DOB _____

Infant's name: _____ DOB _____

- | Mother | Infant |
|---|--|
| <input type="checkbox"/> Sore Nipples | <input type="checkbox"/> Breast Refusal |
| <input type="checkbox"/> Engorgement | <input type="checkbox"/> Latch Difficulties |
| <input type="checkbox"/> Breast Infection (management care) | <input type="checkbox"/> Slow Weight Gain |
| <input type="checkbox"/> Low Milk Supply | <input type="checkbox"/> Mismanagement of Feedings |
| <input type="checkbox"/> Flat or Inverted Nipples | <input type="checkbox"/> Prematurity |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Nipple Thrush | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Relactation | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Prescription for Hospital Grade Breast Pump Date: _____

Physician's Signature: _____

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