



### IBCLC Referral Form

WIC clinic number: \_\_\_\_\_ Referral date: \_\_\_\_\_

Name of referring staff: \_\_\_\_\_

Staff email: \_\_\_\_\_ Staff phone number: \_\_\_\_\_

The WIC Participant authorizes the Local Agency to share their contact information with the IBCLC/DBE:

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Mother's name: \_\_\_\_\_ Mother's DOB: \_\_\_\_\_

Mother's Person ID # or Family ID #: \_\_\_\_\_ Language spoken: \_\_\_\_\_

Preferred Method of Contact:  Email  Phone Call

Mother's email: \_\_\_\_\_ Mother's phone number: \_\_\_\_\_

Baby's name: \_\_\_\_\_ Baby's DOB: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Last known weight/date: \_\_\_\_\_

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Reason for referral (Check all statements which apply):

- Breast/nipple pain
  - Improving latch/ infant not latching
  - Concerns with milk supply
  - Poor or slow weight gain
  - Premature infant
  - Feeding concerns
  - Other: \_\_\_\_\_
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Referral notes: