IBCLC Referral Form

WIC clinic number: _____ Referral date: _____

Name of referring staff:_____

Staff email:_____ Staff phone number:_____

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:_____

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
- ☐ Other:_____

  _____

Referral notes: