Lactation Referral Form

For all other referrals, please email to latch@hsipgh.org or fax to 412.247.1877. If mother is newly postpartum, for immediate assistance, please call 412.545.2022 and select option 1 to reach the lactation counselor on call.

First Name _____ Last Name _____

Birth Date _____ Due Date _____

Anticipated Delivery Site _____

Phone Number _____ Best time to call _____

Address _____

Prior Pregnancies _____ History of Breastfeeding: Y / N

Is Mother a Healthy Start Participant: Y / N

Does Mother identify as Black/African American: Y / N

If Delivered:

Infant Name _____ Birth Date _____

Birth Weight _____ Current Weight _____ Date _____

Reason for Referral

☐LAtCH (Lactation Assessment Counseling Home) Support Program
☐Mother/Family interested in learning more about breastfeeding
☐Sore nipples or other breast problem
☐Preparing to return to work/school
☐Difficulty with latch _____
☐Poor Milk Supply _____
☐Other _____

Is there a concern about Infant weight: Y / N

Notes regarding referral:

_____

_____

_____

Referred By _____ Date _____

Internal Use ONLY

Date(s) Contacted _____ Follow up _____

Appointment Date & Time _____ Counselor _____

400 N. Lexington Ave, Pittsburgh, Pa 15208 **p: 412.545.2022 f: 412.2471877** **latch@hsipgh.org**

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