Lactation Referral Form

Please email to latch@hsipgh.org or fax to 412.247.0187. If mother is newly postpartum or for urgent matters, please call 412.545.2022 and select option 1 to reach the lactation counselor on call for immediate assistance.

First Name _____ Last Name _____

Birth Date _____ Due Date _____

Anticipated Delivery Site _____

Phone Number _____ Best time to call _____

Address _____

Email _____ 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:

_____

_____

_____

Participant's Signature _____ Date _____

Referred By _____ Date _____

Internal Use ONLY

Handoff _____

Follow up _____ Counselor _____