



Breastfeeding & Lactation Medicine Consult Form

Referrals accepted from physician, midwife, nurse practitioner, audiologist, chiropractor, podiatrist, optometrist & physical therapist.
BOTH the parent & infant must be referred, unless referral is for antenatal consult or lactation induction consult prior to birth of infant.

Lactating PARENT Information

Name:

Date of Birth:

Alberta Healthcare Number:

Phone Number:

Parent Email:

INFANT Information

Name:

Date of Birth:

Alberta Healthcare Number:

Referring Provider Information:

Full Name:

Clinic Fax number:

Provider Practice ID (Required):

Clinic Phone number:

Date of referral:

Signature: _____

(or signature of allied healthcare providers sending on behalf of above, thereby certifying verbal approval for referral was obtained).

Status at Time of Referral

Birthweight (kg):

Most recent weight & date of measurement(kg):

Current Feeding (select all that apply):

- Direct Breastfeeding Bottle Feeding Pumping & Expressed Milk Formula Other

Postpartum Consult: Please attach their **delivery note or discharge summary** if available to you.

- | | |
|---|--|
| <input type="checkbox"/> Breastfeeding after breast surgery | <input type="checkbox"/> Nipple trauma & damage |
| <input type="checkbox"/> <u>Current</u> mastitis | <input type="checkbox"/> Nipple pain |
| <input type="checkbox"/> Plugged ducts | <input type="checkbox"/> Suspected nipple "yeast" or "infant thrush" |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Slow infant weight gain |
| <input type="checkbox"/> Suspected low milk supply | <input type="checkbox"/> Suspected oral restrictions (ties, etc) |
| <input type="checkbox"/> Hyperlactation/excess milk supply | <input type="checkbox"/> Suspected infant allergies |
| | <input type="checkbox"/> Other (please specify) |

Antenatal Consult: Estimated Due Date:

- Gestational Diabetes
- History of low milk supply
- Lactation induction (non-pregnant parent desiring lactation)

Please attach prenatal records.

- History of Breast Surgery
- Endocrine Disorders
- Other (please specify)

If you feel this referral is **urgent, please provide support for WHY.**

Parent & Infant Medical History: Past medical hx; Pregnancy/birth; Meds, herbs, & allergies

Strategies tried to date: Latching & Positioning Recommendations; Support for Milk Production; Feeding Tools, etc.

*Referrals faxed to our office will be processed by our staff within 48-72 hours M-F. Clinical situations that you feel should be dealt with more urgently require **phone notification** to our office. Initial consults are scheduled in **1-7 weeks** from receipt of **complete form** & are triaged based on urgency. Please ensure the parent and infant have **adequate care while waiting.***

Please see resources on our website <https://villagelactation.vpweb.com/provider-resources> that may be useful for their care.