Print Form

CITY OF LONG BEACH
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH NURSING
Breastfeeding Support Referral

Referral Date: _____

☐ OB Clinic Patient ☐ Other ☐ BF appt. made for F/U_____

Mother's Information

Name: _____ D.O.B: _____

Discharge Address: _____

Telephone: (Verify with patient) _____ Cell: _____

Primary Language: _____ Discharge Date: _____

Gravida: ☐ Para: ☐ ☐ NSVD ☐ C/S ☐ Singleton ☐ Twin ☐ Fetal Demise

Feeding Choice: ☐ Exclusive Breastfeeding ☐ Breast & Artificial Breast Milk

Baby Information

☐ Male ☐ Female Date of Birth: _____ Time of Birth: _____

G.A. _____ Birth Weight: _____ Date of Discharge: _____

Pediatrician: _____

Hospital Feeds: ☐ Exclusive Breatfeeding ☐ Mostly Breastfeed (75% or more)

Health Issues: _____

Indications for Referral
(Must check all that apply)

☐ Desires to breastfeed ☐ Pre-term (<34 wks) ☐ Nipple problems
☐ Jaundice ☐ Poor/inconsistent latch ☐ First time Breastfeedng
☐ Weight loss (>10%) ☐ Teen mother ☐ Needs additional support/education
☐ Separated from mother ☐ Late Pre-term (34-37 wks) ☐ Breast Milk Suppression

☐ Other

Referred by: _____ Contact Information: _____

Please fax form to: (562) 570-4099 Attn: Danielle Sees, IBCLC

OFFICE USE ONLY
Record Searched_____ Census_____ DT_____