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**Lactation Consultant – Referral form**

Please email this form to [kchft.lactationconsultants@nhs.net](file:///C:\Users\Mary.Vacher\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.IE5\2ZQPA0TF\kchft.lactationconsultants@nhs.net)

|  |  |  |  |
| --- | --- | --- | --- |
| Mother’s name: | | Baby’s name: | |
| Mother’s age: | Baby’s gestational age: | | Age of baby today: |
| Contact number: | Birth weight: | | Birth centile: |
| History of breastfeeding  Yes/No | Current weight: | | Current centile: |
| Mother’s NHS NO | | Baby NHS No: | |
| Referred by | | Contact number (referrer) | |
| Referrer’s name: | | Date of referral: | |
| Profession:  Midwife/GP/Health Visitor/ Breastfeeding Counsellor / Paediatrician/Other | | If other name of service | |
| Referrers address: | | | |
| Has a feeding assessment been completed and documented in the Red Book YES/NO | | | |

**Reason for Referral**

|  |  |
| --- | --- |
| Difficulty with latch | Yes/No |
| Poor milk supply | Yes/No |
| Sore nipples or other breast problems | Yes/No |
| Slow weight gain | Yes/No |
| Breast refusal | Yes/No |
| Illness/condition | Yes/No |
| Specialist condition e.g. cleft palate | Yes/No |
| Flat or inverted nipples | Yes/No |
| Suspected restricted frenulum | Yes/No |
| Induced lactation or re-lactation | Yes/No |
| Other | Yes/No |
| If other further information required: | |

**Additional information**

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